

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Helen		Middle Jane		Last ADAMS		2a. DATE OF DEATH Month NOVEMBER Day 8 Year 1968		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH Aug. 12, 1909			6. AGE (In years last birthday) 59 YRS.		2b. HOUR 6:10 PM		
7a. BIRTHPLACE (State or foreign country) Dorchester		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.					
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Dorchester		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 604 Academy Street				
14. FATHER'S NAME First Matthew			Middle Travers		Last Elizabeth		15. MOTHER'S MAIDEN NAME First Elizabeth Middle Lewis Last Prince Street				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Charles E. Hill, Salisbury, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) H CVD PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/10 , 19 68 , to 11/8 , 19 68 , that (I) (we) last saw the deceased alive on 11/6 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. B. Smith DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/9/68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Nov. 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial		23d. LOCATION (City or Town) (County) (State) Park, Cambridge Dor. Md.				
24. FUNERAL DIRECTOR Kenneth R. Thomas Jr. ADDRESS 700 LOCUST ST. CAMBRIDGE						25a. REC'D BY REGISTRAR DATE NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

1500



[Faint, mostly illegible text and markings covering the majority of the page. Some words like "1500" and "1500" are visible in the top right and middle right areas respectively.]

[Faint text at the bottom of the page, possibly a footer or additional notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <i>Irving</i> First <i>Powell</i> Middle <i>Adkins</i> Last			2a. DATE OF DEATH Month <i>November</i> Day <i>24</i> Year <i>68</i>			2b. HOUR M						
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 25, 1910</i>			6. AGE (In years last birthday) <i>58</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i>			Md.			
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt 3 Shavox Road</i>			
14. FATHER'S NAME First <i>George</i> Middle <i>Adkins</i> Last			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Mills</i> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Rosetta Adkins</i>			Address <i>Rt. 3 Salisbury, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4339 Cerebral Thrombosis</i> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>332x</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes Mellitus</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <i>4/22 68</i> City or Town <i>Salisbury</i> County <i>Wicomico</i> State <i>Md.</i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>4/22 68</i> to <i>4/24 68</i> , that (I) (we) last saw the deceased alive on <i>4/24 68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>David J. Wallace</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>11-26-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parsons Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Salisbury Md.</i>				
24. FUNERAL DIRECTOR <i>Thomas F. Wallace</i>						25a. REC'D BY REGISTRAR DATE <i>NOV 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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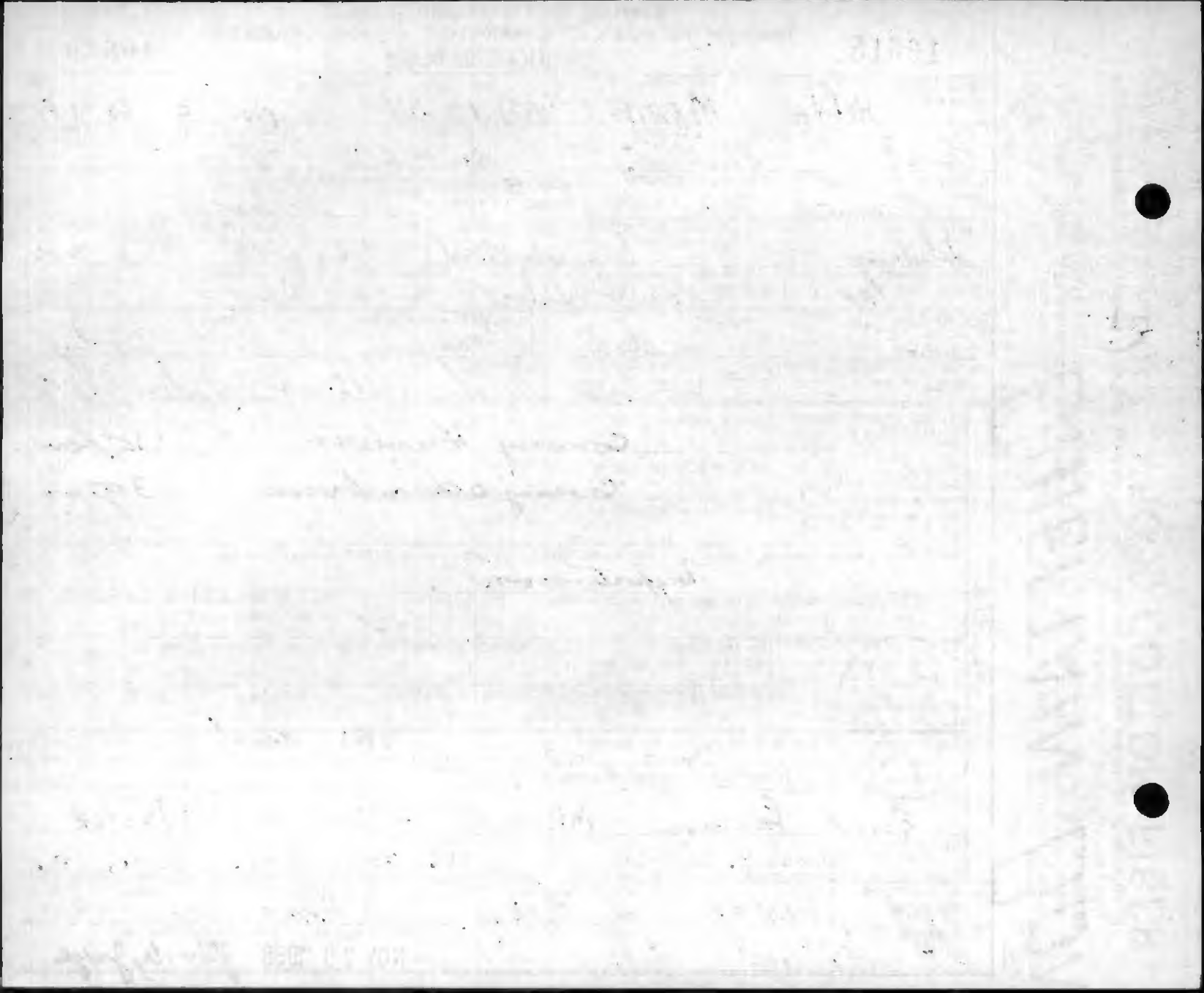
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16618										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16630									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
HILDA MARIE ATKINSON										Month Nov Day 9 Year 63										1 P M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Female			White			Jan. 14, 1898			70			MONTHS			DAYS			HOURS			MIN.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Wisconsin			US						Wisconsin												Md.								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Delaware					Lansdowne Good					Housewife					Home														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
MD					Delmar					Delmar					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					Rd 3									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Ernest					Reddish					Mary										Corday									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
					221-03-1105					Norman K. Adkins					Delmar Rd 3 Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Coronary Thrombosis																				2-4 hours									
4109 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) Coronary atherosclerosis																				3 years									
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
4201 Hypertension																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 1963 to death, 1968, that (I) (we) last saw the deceased alive on Nov 7 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Ernest Larmore M.D. DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 11/26/68									
22d. PHYSICIAN'S NAME (Type) Ernest M. Larmore										22e. ADDRESS 100 Grove Street Delmar, Del.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 11/26/68					23c. NAME OF CEMETERY OR CREMATORY St. Stephens					23d. LOCATION (City or Town) (County) (State) Delmar Sussex Del														
24. FUNERAL DIRECTOR William J. Moore ADDRESS Delmar Del										25a. REC'D BY REGISTRAR DATE NOV 29 1968										25b. REGISTRAR'S SIGNATURE J. Charles Judge									



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MEDICAL CERTIFICATION

16617										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16631									
1										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					20. DATE OF DEATH					26. HOUR														
EDITH					PEARL					BAILEY					11 Month 26 Day Year 1968					11:10 A									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years lost birthday)					7. UNDER 1 YEAR					8. UNDER 24 HRS				
Female					White					October 3, 1901					67 YRS.					MONTHS DAYS HOURS MIN									
70. BIRTHPLACE (State or foreign country)					75. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Maryland					USA										Wicomico					Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					126. KIND OF BUSINESS OR INDUSTRY														
Salisbury					Deer's Head State Hospital					Retired Maid					---														
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					132. CITY OR TOWN					134. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					136. STREET AND NUMBER														
Maryland					Worcester					Ocean City					1st & Philadelphia Ave.														
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
Levin James Clark					Sarah Gertrude Davis																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT (Daughter)					R.D. Address					Friendship Road									
No					214-32-6139					Mrs. Hilda E. White, Pittsville, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Adenocarcinoma of bile duct with metastasis to liver															2 yrs														
1561																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																													
DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
1551																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (this hospital) attended the deceased from 10/21, 1968, to 11/26, 1968, that (we) last saw the deceased alive on 11/26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE															22c. DATE SIGNED														
L. V. Maldve, M. D.															11/26/68														
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS														
L. V. Maldve, M. D.															Deer's Head State Hospital; Salisbury, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Nov. 30, 1968					Parsons Cemetery					Salisbury, Wicomico, Maryland														
24. FUNERAL DIRECTOR ADDRESS															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
HOLLOWAY & COMPANY, SALISBURY, MARYLAND															DATE DEC 2 1968					f Charles Judge									

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VR A15 41
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <i>Mary Elizabeth Beach</i>					2a. DATE OF DEATH <i>11 Month 13 Day 1968</i>		2b. HOUR <i>M</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11/12/1874</i>		6. AGE (In years by birthday) <i>94</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.			
10. CITY OR TOWN OF DEATH <i>Rural Sharptown</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>RFD #2 Delmar, Del.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housework</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Wicomico</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <i>Josiah Owens</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>Adeline Cooper</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>222-34-9703</i>		17. INFORMANT <i>Mrs. May Twilley, Delmar, Del.</i>			Address <i>RFD #2 Sharptown</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>4339</i> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>approx. 1 hour</i> <i>Unknown</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>332X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/11, 1968</i> , to <i>death</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/13/1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Ernest Larmore</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>11/16/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Ernest M. Larmore</i>						22e. ADDRESS <i>100 Grove St. Delmar, Del. 19940</i>			
23a. BURIAL, CREMATION REMOVED <i>Buried</i>		23b. DATE <i>11/15/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Firemen's</i>		23d. LOCATION (City or Town) (County) (State) <i>Sharptown, Md.</i>			
24. FUNERAL DIRECTOR <i>NEWMAN FUNERAL HOME, Sharptown, Md.</i> ADDRESS						25a. REC'D BY REGISTRAR DATE <i>NOV 19 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

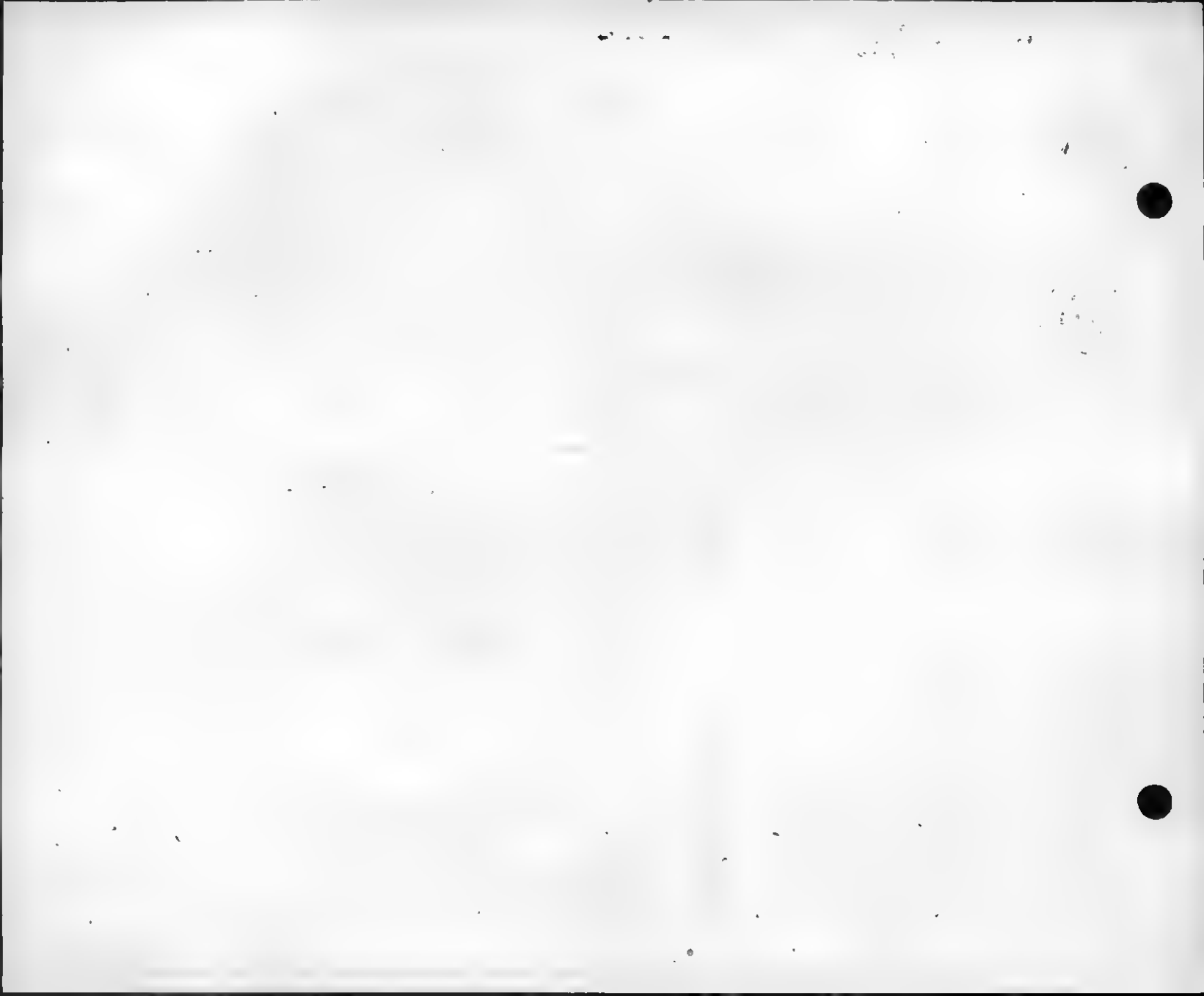
16619

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16619

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M		
CLARICE				LESTON	BLACK	November 8 1968					
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male	White		October 21, 1895			73 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Pennsylvania		USA				WICOMICO Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hebron			Rewastico Road			Retired Chief Machinist			US Navy		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Wicomico		Hebron			Rewastico Road			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Charles				Black		Ara			Vada	Ramsey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT (Wife)			Address		
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> War I & II			483-01-1267			Mrs. Frances D. Black, Hebron, Maryland			Rewastico Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central viral infection</u> <u>799</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION		Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> , 19 <u>67</u> , to <u>11/8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>S. H. Hurdle</u>						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>11/8/68</u>		
22d. PHYSICIAN'S NAME (Type) Dr. S. H. Hurdle						22e. ADDRESS Hebron, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE Nov. 8, 1968		23c. NAME OF CEMETERY OR CREMATORY John Hopkins University School of Medicine, Baltimore, Md			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REG. STRAR DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16620

16620

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
VIOLA		E.		BRIMER	November 11, 1968		6:55 PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White		May 31, 1887		81 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Maryland		U.S.A.				WICOMICO Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Salisbury		Deer's Head State Hospital		Housewife		---		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Somerset		Crisfield				Box 206
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last					
James W. Revelle			Minerva -- Catlin					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address				
No		none		Mrs Herbert Groton, Pocomoke City, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u>								1 day
4121 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease, decompensated.</u>								years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4221 (c) <u>pensated.</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
<u>Fracture of left femur with surgery.</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (X) (this hospital) attended the deceased from <u>October 1, 1968</u> to <u>November 11, 1968</u> , that (X) (we) last saw the deceased alive on <u>November 11, 1968</u> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (d.d.) (d.d.d.) view the body after death.								
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)				
<u>L. V. Maldve, M. D.</u>		11/12/68		Maryland				
				Deer's Head State Hospital, Salisbury,				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY		23d LOCATION (City or Town) (County) (State)		
Burial		11-14-1968		Salem Methodist		Pocomoke City-Wor-Md.		
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
<u>Robert H. Watson</u> Pocomoke City, Md.				DATE NOV 15 1968		<u>Charles Judge</u>		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16621

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16621

1 DECEASED-NAME (Type or Print)		First JOHN		Middle W.		Last BRITTINGHAM		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-14-68		2b HOUR 2:50 P	
3. SEX M	4 RACE W	5. DATE OF BIRTH 4-20-11	6 AGE (in years last birthday) 57 YRS.	F UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD Month 11 Day 14 Year 68		2d HOUR 2:50 P	
7a BIRTHPLACE (State or foreign country) LAUREL DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico				Md	
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) POULTRY RAISOR		12b KIND OF BUSINESS OR INDUSTRY POULTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b COUNTY Worcester		13c CITY OR TOWN Ocean City		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4 N. Baltimore Ave.			
14 FATHER'S NAME First HORACE		Middle BRITTINGHAM		Last MARGARET		15. MOTHER'S MAIDEN NAME First LOWE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give war or dates of service) 218-34-8845		17. INFORMANT ADDRESS MRS. W. W. BRITTINGHAM						OCEAN CITY, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4301											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Earl L. Royer M.D. 409 Camden Ave., Salisbury, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED Nov. 15, 1968			
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
BURIAL		11/17/68		EVERGREEN		BERLIN		WOR		MD	
24 FUNERAL DIRECTOR Barbage Funeral Home		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
						NOV 19 1968		J. Charles Judge			



FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16622

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16622

1 DECEASED NAME (Type or Print) First Middle Last LAFAYETTE LAMAR BROWN			2a DATE KNOWN OF DEATH Month Day Year 11-5-68 19			2b HOUR M					
3 SEX Male		4 RACE AA		5 DATE OF BIRTH 5-11-58		6 AGE (In years last birthday) 10 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Wicomico Md		
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General School			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) School			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Wicomico			13c CITY OR TOWN Salisbury			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 32 Waconia Ave.			14 FATHER'S NAME First Middle Last Abraham Brown			15 MOTHER'S MAIDEN NAME First Middle Last Pearl Brown			16 ADDRESS Salisbury, Maryland		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO. (If yes give war or dates of service)			17 INFORMANT Pearl Brown			18 ADDRESS Salisbury, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3147 Fracture dislocation of cervical spine DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 812.4											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year 5:30 P.M. 11-5-68			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Pedestrian hit by automobile.					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) road			21f LOCATION Street or R.F.D. No City or Town County State West Road, Salisbury, Wicomico, Md.					
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Earl L. Royer, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) 409 Camden Ave, Salisbury, Md			ADDRESS (Street, city, town or county)			22b DATE SIGNED Nov. 8, 1968					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 11/9/68			23c NAME OF CEMETERY OR CREMATORY Mardala Cemetery			23d LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.		
24 FUNERAL DIRECTOR Clinton Stewart			ADDRESS Salisbury, Md.			25a REC'D BY REG. STRAR NOV 13 1968			25b REGISTRAR'S SIGNATURE Charles Judge		

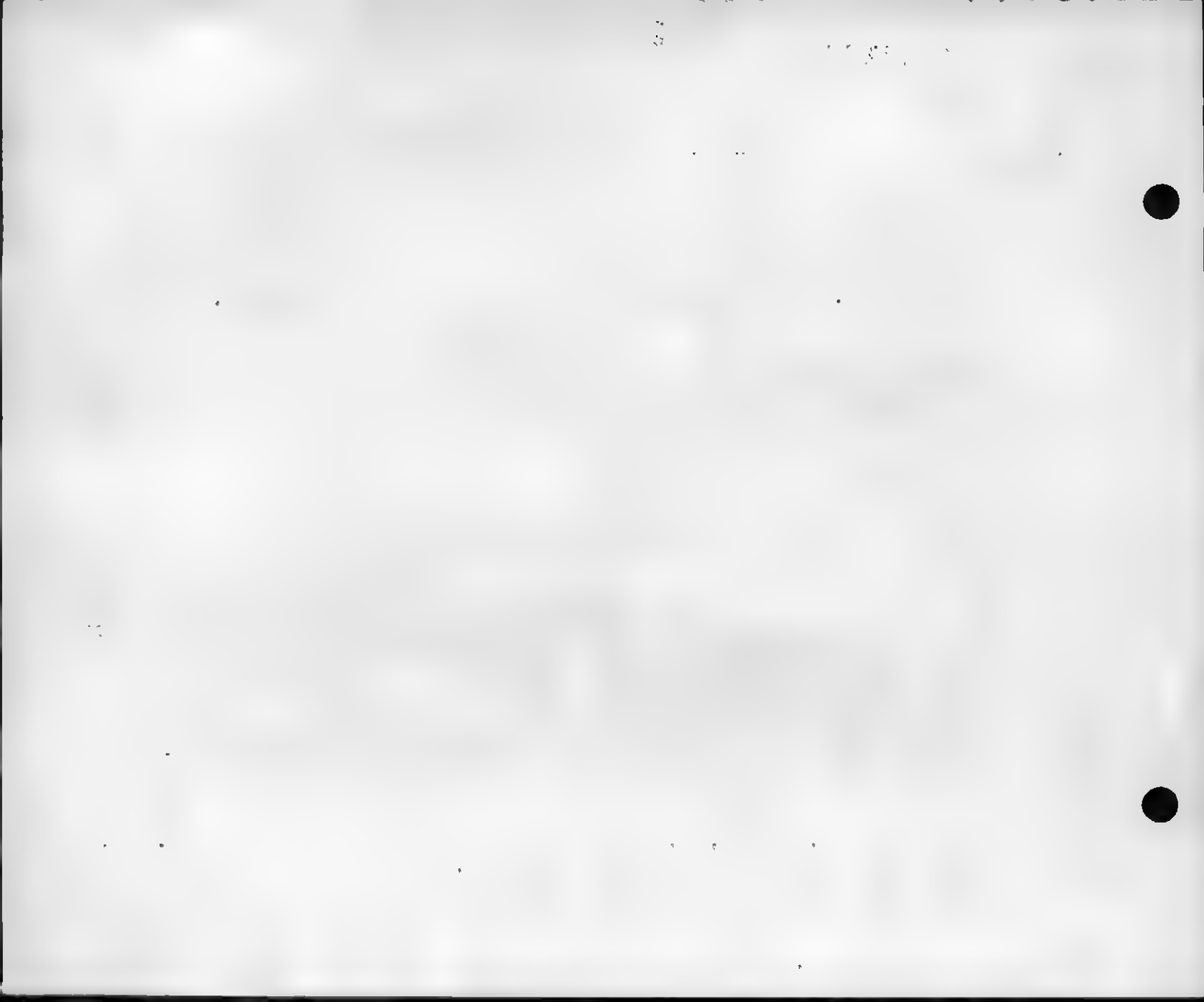


FOR STATE HEALTH DEPT.

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Item 2a File No. 107 12/3/68 kk 16623										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1968				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																								
1. DECEASED-NAME (Type or Print) : : : JOE					First Middle Last					2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 11 7 19 68					2b. HOUR M									
3 SEX Male		4. RACE AA		5. DATE OF BIRTH 12-19-19		6. AGE (in years last birthday) 48 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 11 Day 8 Year 1968					2d. HOUR 5:50 PM							
7a. BIRTHPLACE (State or foreign country) Unknown					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					9. COUNTY OF DEATH Wicomico Md									
10. CITY OR TOWN OF DEATH Salisbury					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Lake St.					12a. LSLA. OCCUPATION (Kind of work done during most of working life, even if retired) laborer					12b. KIND OF BUSINESS OR INDUSTRY None									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.					13b. COUNTY Wicomico					13c. CITY OR TOWN Salisbury					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER Lake St.				
14. FATHER'S NAME First Middle Last Unknown					15. MOTHER'S MAIDEN NAME First Middle Last Unknown																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown					16b. SOCIAL SECURITY NO 26786-9440					17. INFORMANT Police Dept					ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) 4109 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (c) 4109 DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION 11-23-68										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day Year 19 HOUR A.M. P.M.					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No City or Town County State														
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																								
ACTUAL SIGNATURE Earl L. Royer, M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED Nov. 14, 1968				
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md										ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county)																								
23a. BURIAL, CREMATION, OR REMOVAL Special					23b. DATE 11-23-68					23c. NAME OF CEMETERY OR CREMATORY Glass Hill Cem					23d. LOCATION (City or Town) (County) (State) Wicomico Md									
24. FUNERAL DIRECTOR Booker West, Salisbury, Md.										25a. REC'D BY REGISTRAR NOV 22 1968										25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 115-115
45M

16624

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10123

1. DECEASED-NAME (Type or print) Willie Ernest Corrigan			2a. DATE OF DEATH Month November Day 21 Year 1968			2b. HOUR 6:50 M	
3. SEX male		4. RACE Negro		5. DATE OF BIRTH 3-8 1907		6. AGE (n years lost birthday) 61 YRS	
7a. BIRTHPLACE (State or foreign country) Summerton, S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) MARYLAND		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13e. STREET AND NUMBER 515 COLLINS STREET	
14. FATHER'S NAME First MOSE Middle CARRIGAN Last CARRIGAN		15. MOTHER'S MAIDEN NAME First ERVETT Middle BROWN Last BROWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES WWII		16b. SOCIAL SECURITY NO. 220-10-842		17. INFORMANT Willie E. CARRIGAN JR. Address 515 COLLINS ST. SALISBURY, MD.			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 da.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from 11-9-68 to 11-21-68 , that (I) (we) lost 11-21-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. E. Ellis, Jr. DEGREE _____ ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 11-25-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11-27-68		23c. NAME OF CEMETERY OR CREMATORY GREEN ACRES		23d. LOCATION (City or Town) (County) (State) SALISBURY - WICO. MD.	
24. FUNERAL DIRECTOR Laurel B. Jolly Address Jerry Rd. 112 Salisbury, Md.				25a. REC'D BY REGISTRAR NOV 29 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in paragraph 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

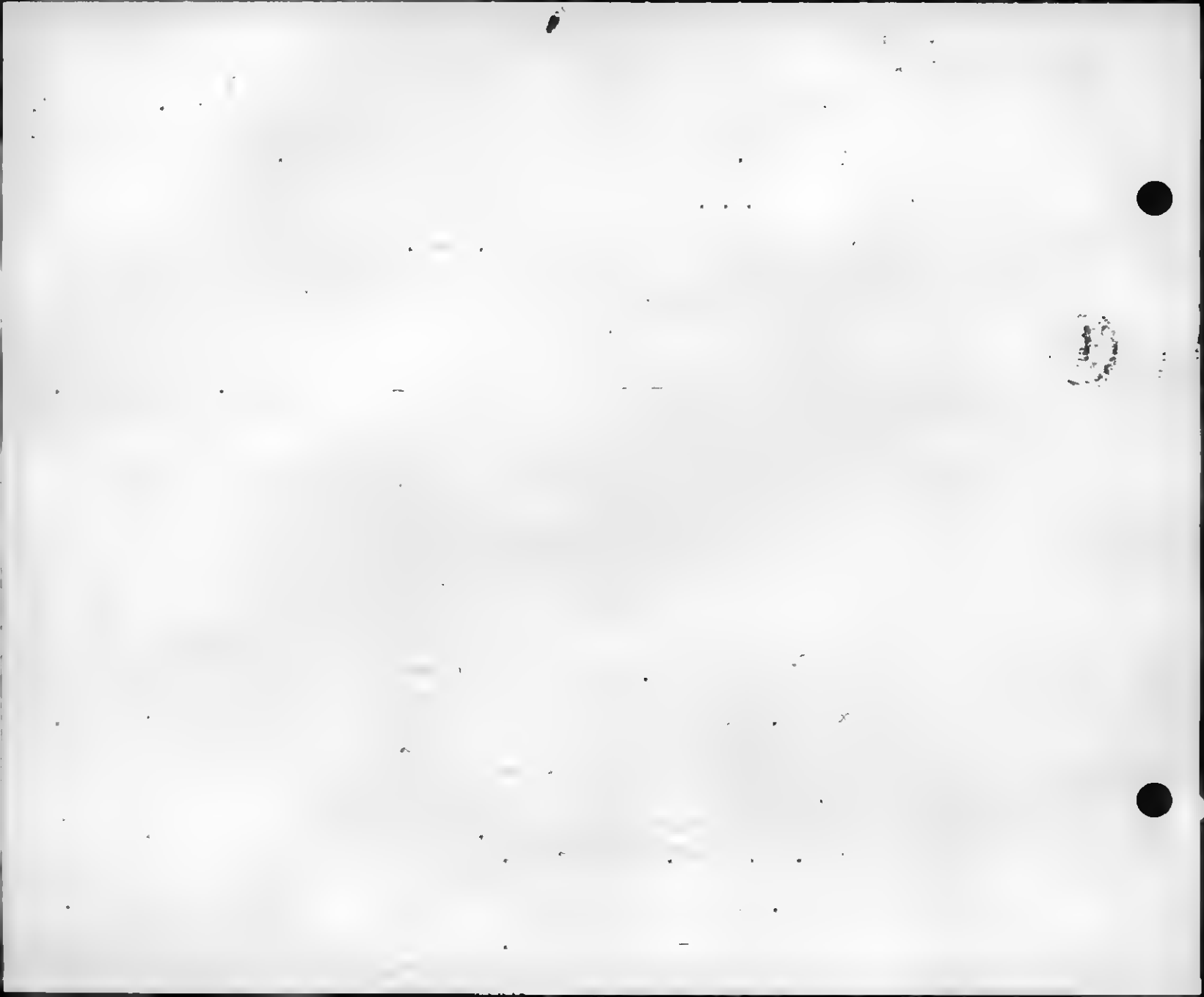
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16625

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1968

1 DECEASED NAME (Type or Print)		First JAMES		Middle HANDY		Last DAVIS		2a DATE KNOWN OF DEATH Month Nov. Day 9 Year 1968		2b HOUR 7:35 AM	
3 SEX Male	4 RACE White	5. DATE OF BIRTH Oct. 26, 1884	6 AGE (In years last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Nov. Day 9 Year 1968		2d HOUR 7:35 AM			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico				Md	
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula Gen. Hosp.				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Farmer		12b KIND OF BUSINESS OR INDUSTRY Farming			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Somerset		13c CITY OR TOWN Rehobeth		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Rural			
14 FATHER'S NAME First James Middle Davis Last Davis		15 MOTHER'S MAIDEN NAME First Olevia Middle - Last Hayman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 215-38-1721		17. INFORMANT Gene Bailey-411 Dudley Ave.-Pocomoke, Md.		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fracture dislocation cervical spine											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 7:00 PM Oct. 16 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto accident (involving 2 cars)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Md. Rt. # 667		21f LOCATION Street or RFD No. City or Town County State 1 mile north of: Marion - Somerset- Md.							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Earl L. Royer		EXAMINER'S NAME (Type) Earl L. Royer, MD. Salisbury, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED Nov. 12, 1968					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Nov. 12, 1968		23c NAME OF CEMETERY OR CREMATORY Rehobeth Baptist Cemetery		23d LOCATION (City or Town) (County) (State) Rehobeth-Somerset-Md.					
24 FUNERAL DIRECTOR Bradshaw & Sons - Crisfield, Md.		ADDRESS		25a REC'D BY REGISTRAR NOV 14 1968		25b REGISTRAR'S SIGNATURE Charles Judge					

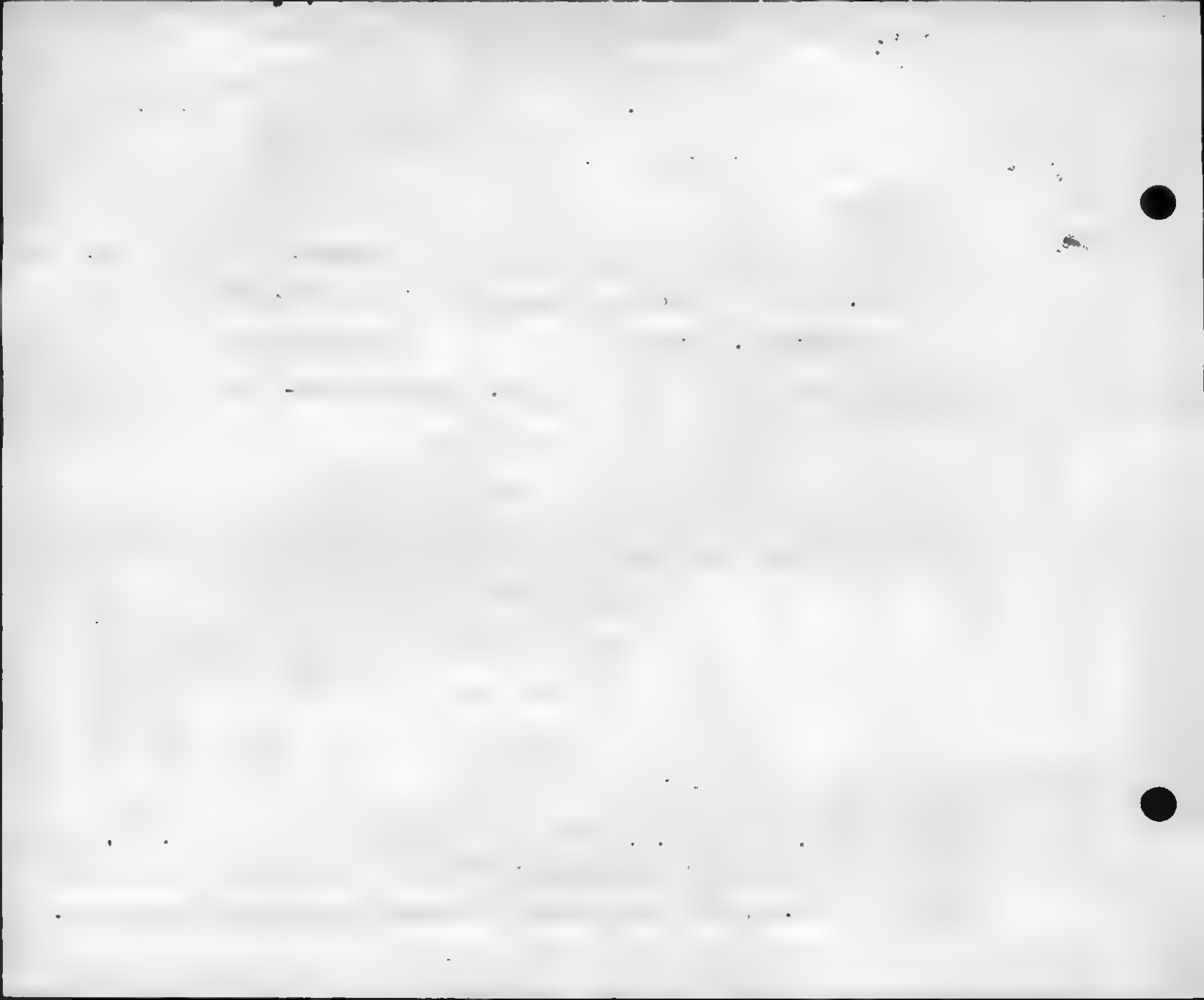


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>16626</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>																							
1. DECEASED NAME (Type or Print)			First LESTER			Middle W.			Last DAVIS			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 11-18-68			2b. HOUR 5:30 P								
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-21-26		6. AGE (In years last birthday) 41 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 11 18 68			2d. HOUR 3:30 P								
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Wicomico				Md							
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer				12b. KIND OF BUSINESS OR INDUSTRY Textile											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Knox Street									
14. FATHER'S NAME First Middle Last Clarence W. Davis						15. MOTHER'S MAIDEN NAME First Middle Last Myrtle Deremer																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO (If yes give war or dates of service) War II				17. INFORMANT ADDRESS Mrs. Virginia Davis-Wife															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4109																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State															
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED Nov. 19, 1968							
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.				ADDRESS 409 Camden Ave., Salisbury, Md.				23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE Nov. 22, 1968				23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR				ADDRESS Scarpelli Funeral Home, Cumberland, Md.				25a. REC'D BY REGISTRAR NOV 22 1968				25b. REGISTRAR'S SIGNATURE <i>John J. Jones</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

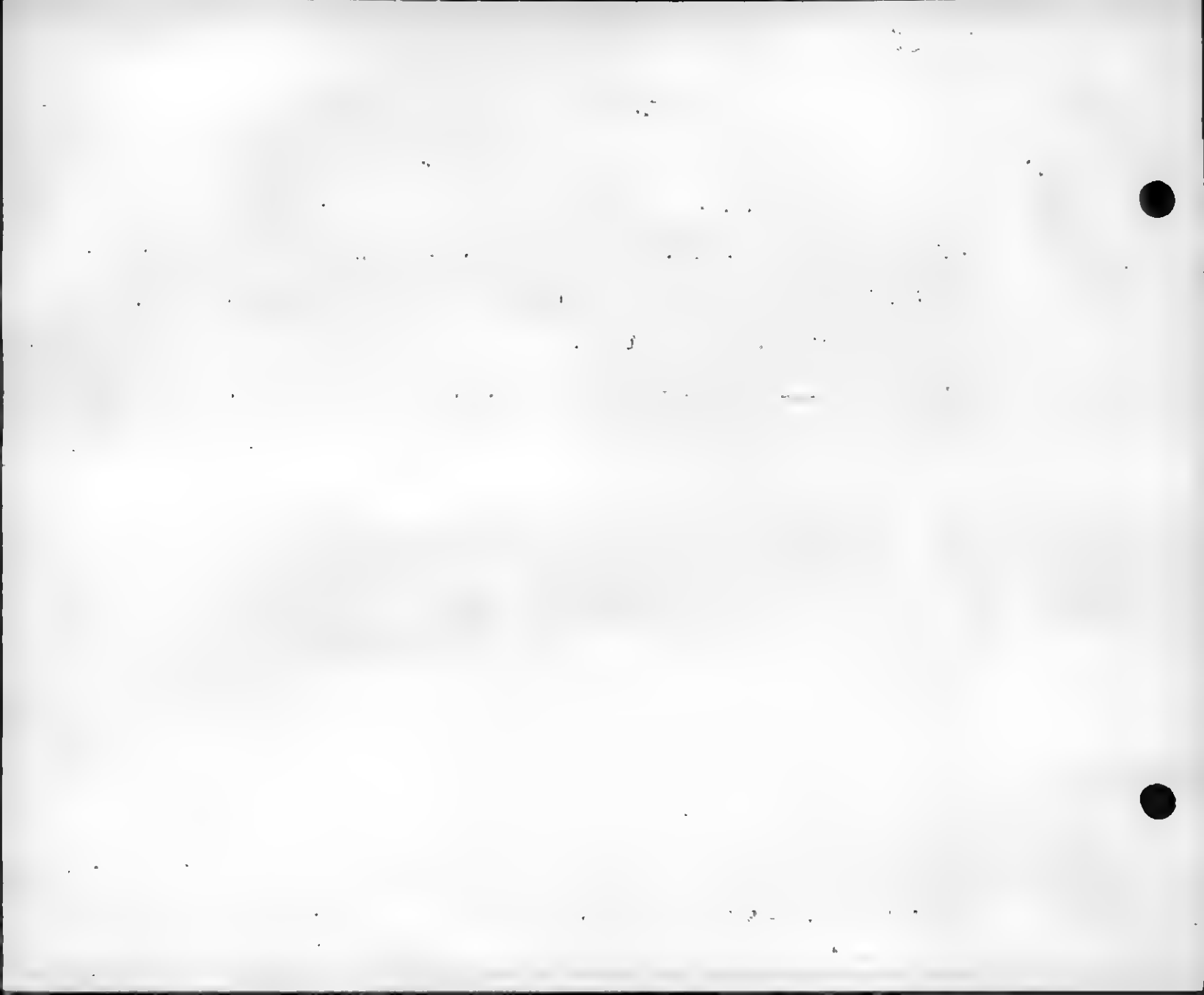
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16627

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16741

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
BARBARA		ESTELLA	DEANSON	Month 11 Day 1 Year 1968		1:30		AM
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female	White		July 22, 1988		80 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U.S.A.				Wicomico MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital		House wife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Wicomico		Salisbury				1002 Camden Ave.,
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
First Middle Last William T. Phillips			First Middle Last Estella Price					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No		220-52-8828		Mrs. R.R. Purnell, See Sec. #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma rectum & metastasis to obstruction</u>								6 mos
1541 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
1541								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 10-22, 1968, to 11-1, 1968, that (I) (we) last saw the deceased alive on 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
Nevins W. Todd Jr.		11-4-68						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Nevins W. Todd Jr.		Med. Ctr. - Salisbury - Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		11-4-1968		Siloam Cemetery		Siloam, Wicomico, Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hill Funeral Home Salisbury, Maryland				DATE NOV 6 1968		J. Charles Judge		



FOR STATE HEALTH REPORT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

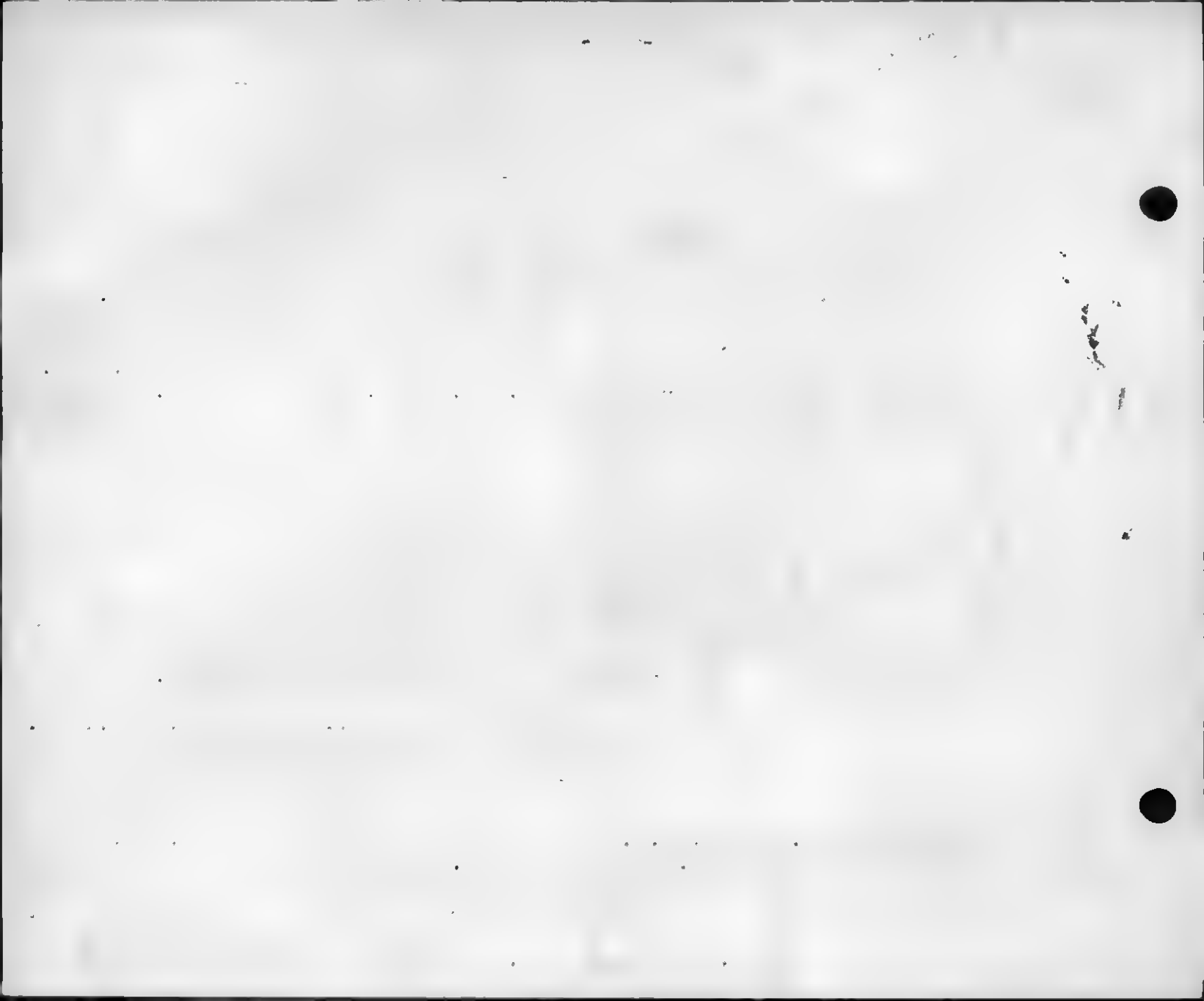
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16628

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10540

1 DECEASED NAME (Type or Print) First Middle Last ALICE FLORENCE DUCK			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-24-68 1968			2b HOUR 9 A M			
3 SEX Female	4 RACE White	5 DATE OF BIRTH 2-7-18	6 AGE (In years, last birthday) 50 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 11 Day 24 Year 1968			
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico Md			
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House work & Canning		12b KIND OF BUSINESS OR INDUSTRY Factory		
13a USUAL RESIDENCE (Where deceased lived, if not location: Residence before admission) STATE Md.		13b COUNTY Wicomico		13c CITY OR TOWN Fruitland		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Main & Brown Sts.	
14 FATHER'S NAME First Middle Last George T. Williams			15 MOTHER'S MAIDEN NAME First Middle Last Mamie Evelyn Ennis						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give war or dates of service) 213-16-8314		17 INFORMANT (son) Mr. Wm. Duck, Salisbury, Md.			ADDRESS 1507 S. Div.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide poisoning DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 10-28-68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Faulty furnace at own home.					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) own home		21f LOCATION Street or RFD No. City or Town County State Main & Brown Sts., Fruitland, Wic., Md.					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED Nov. 26, 1968	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 11-27-68		23c NAME OF CEMETERY OR CREMATORY Smullen Cemetery			23d LOCATION (City or Town) (County) (State) Worcester, Md.		
24 FUNERAL DIRECTOR Holloway & Company, Salisbury, Md.				25a REC'D BY REGISTRAR DEC 2 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

30M REV 1/68

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> 16629 MARYLAND STATE DEPARTMENT OF HEALTH 16643 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>													
1 DECEASED NAME (Type or print)				First Middle Last				2a DATE OF DEATH Month Day Year				2b HOUR AP, M	
Elbert				F.				Duckery				Nov. 29 1968	
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		Negro		March, 1, 1891				77 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Md.		U.S.A.				Wicomico Md.							
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Salisbury				Deer's Head State Hospital				Trackman				Pa. R.R.	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.				Kent		Millington				None			
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last									
Elbert Duckery				Dora Starling									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT Address							
				717-07-9029		Mrs. Florence L. Duckery, Millington, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion & Edema</u>												Days	
4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>												Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Nephrosclerosis</u>												Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
442x													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/11/68</u> , 19 <u> </u> , to <u>11/29/68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>11/29/68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Andrew C. Mitchell</u> DEGREE								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED Nov. 30, 1968			
22d. PHYSICIAN'S NAME (Type) Andrew C. Mitchell, M. D.								22e ADDRESS P.O. Box 2018, Salisbury, Maryland-21801					
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial				Dec. 5, 1968		Millington Cemetery				Millington Kent Md.			
24 FUNERAL DIRECTOR ADDRESS Edward Fellows & Son, Millington, Md. 21651								25a REC'D BY REGISTRAR DATE DEC 3 1968		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

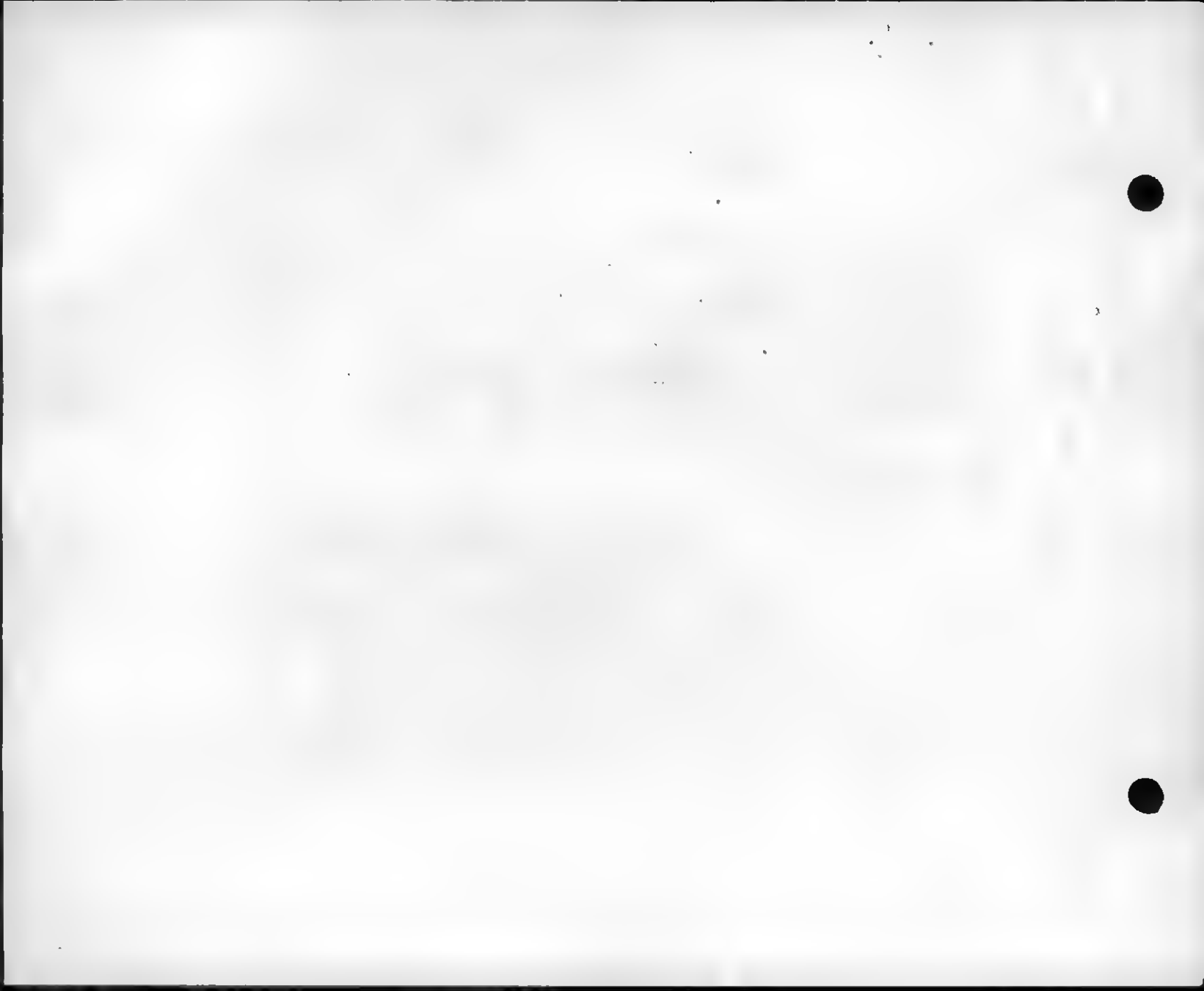
VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16630

1664

1. DECEASED-NAME (Type or print) <i>John Larry DUKES</i>			2a. DATE OF DEATH Month <i>NOVEMBER</i> Day <i>17</i> Year <i>1968</i>			2b. HOUR <i>12:00 PM</i>	
3. SEX <i>MALE</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>25 September 1910</i>		6. AGE (In years last birthday) <i>58</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Delaware</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.	
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Delaware</i>		13b. COUNTY <i>Sussex</i>		13c. CITY OR TOWN <i>Millsboro</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>Larry E. Dukes</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Lara Timmons</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>			
16b. SOCIAL SECURITY NO. <i>222-01-2297</i>		17. INFORMANT Address <i>Aline E. Collins Millsboro, Delaware</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Perforated duod. ulcer.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i> <i>12 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>541.1 Abnormal Timmons</i>							
19a. DATE OF OPERATION <i>11/05/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Perforated ulcer</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11-05</i> , 19 <i>68</i> , to <i>11-17</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-17</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joseph R. Fitzgerald M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>20 November 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dagsboro Memorial</i>		23d. LOCATION (City or Town) (County) (State) <i>Dagsboro, Sussex, Delaware</i>	
24. FUNERAL DIRECTOR <i>Ronald Jones - Millsboro, Del.</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 19 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1043. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

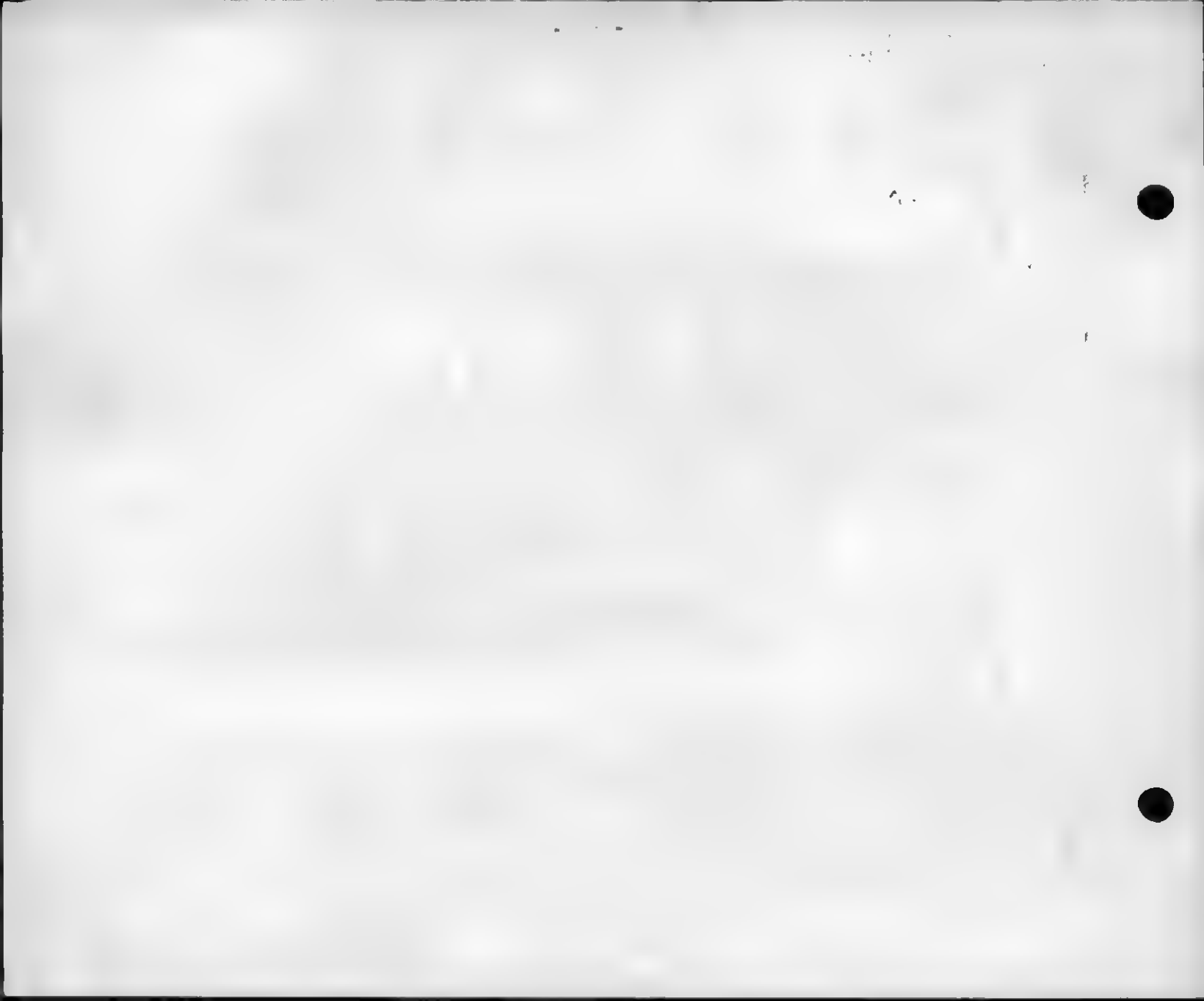
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16631

DIVISION OF VITAL RECORDS, 301 "W." PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1664.

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
JAMES HOOPER ELLIOTT						11/20 1968			5:40 AM						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 1 YEAR	8. IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			Month Day Year			2d. HOUR			
Male	White	January 17, 1916	52 YRS	MONTHS	DAYS	November 20			1968			5:40 AM			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH						
Maryland			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			WICOMICO						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. JSUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury			Peninsula General Hospital			Salesman			Baking Co.						
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admision) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
Maryland			Wicomico			Salisbury			YES <input type="checkbox"/> NO <input type="checkbox"/>			117 Civic Avenue			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT (Wife) ADDRESS			
Irving James Elliott			Mary Green			No			214-10-7607			Mrs. Delsie Elliott, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>												sudden			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <u>1109</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION															
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
22b. DATE SIGNED															
November /1968															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town, or County)							
Earl L. Royer, M.D.															
409 Camden Ave., Salisbury, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				Nov. 23, 1968				Springhill Memory Gardens, Salisbury, Wicomico, Maryland							
24. FUNERAL DIRECTOR				ADDRESS				25a. REGISTRY REGISTRATION NO.				25b. REGISTRY SIGNATURE			
HOLLOWAY & COMPANY, SALISBURY, MARYLAND								NOV 25 1968							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV 1-68

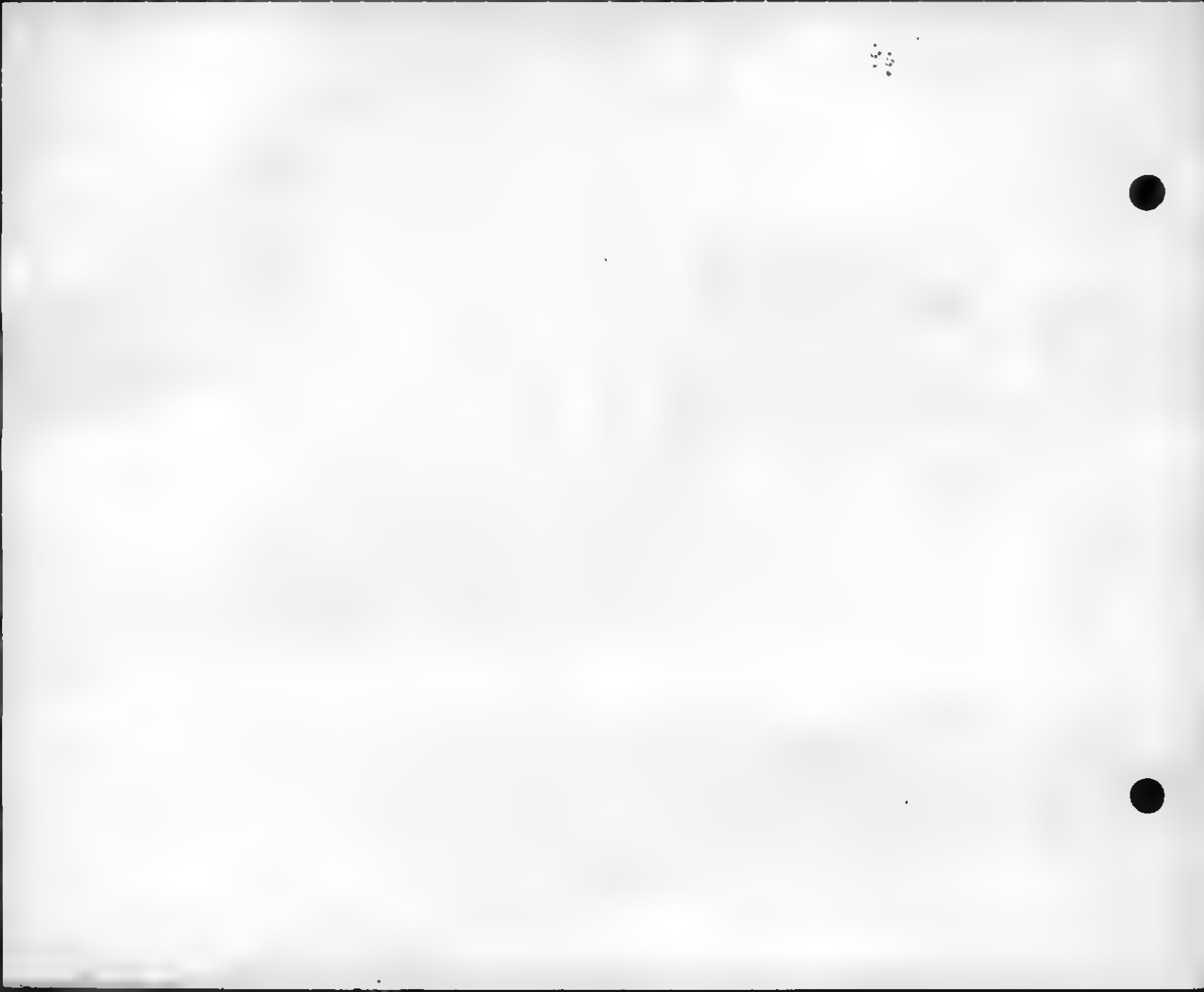
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16632

16632

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) John Edward Farlow			2a DATE OF DEATH Month November Day 6 Year 68			2b. HOUR M	
3. SEX Male		4. RACE WHITE		5 DATE OF BIRTH JAN. 25, 1958		6 AGE (In years last birthday) 10 YRS.	
7a BIRTHPLACE (State or foreign country) SALISBURY		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico	
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm. state) MARYLAND		13b COUNTY WORCESTER		13c CITY OR TOWN OCEAN CITY		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First John T. Middle Farlow Last Farlow		15 MOTHER'S MAIDEN NAME First Virginia Middle Parsons Last Parsons		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, as unknown) No (If yes give year or dates of service)		16b SOCIAL SECURITY NO No	
17 INFORMANT Mrs. Virginia Massey		Address Ocean City, Md		18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peritonitis DUE TO, OR AS A CONSEQUENCE OF (b) Perforated Appendix DUE TO, OR AS A CONSEQUENCE OF (c) 5501 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Microcephaly & severe Physical & Mental Retardation							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from 11/5 , 1968, to 11/6 , 1968, that (1) (we) last saw the deceased alive on 11/5 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b SIGNATURE Alfred C. Kalls		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/6/68			
22d. PHYSICIAN NAME (Type)		22e. ADDRESS Medical Center Salisbury Md		23a NAME OF CEMETERY OR CREMATORY EVERGREEN		23b. LOCATION (City or Town) (County) (State) Berlin Wor. Md	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 11/8/68		23c NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) Berlin Wor. Md	
24. FUNERAL DIRECTOR Anne A. Burbage		ADDRESS Berlin Md		25a REC'D BY REGISTRAR NOV 12 1968		25b REG STRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

16633

16644

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
KEVIN		C	FAUST	NOVEMBER 4 1968		11:45 P M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
MALE	WHITE	JULY 12, 1968		4 YRS		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		
MARYLAND	USA			Wicomico		Salisbury		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
General Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
MARYLAND		Wicomico	SALISBURY		113 HEARTWOOD DRIVE			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MA DEN NAME		First	Middle
PAUL D		FAUST	NORA	N.	RAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
				PAUL D FAUST		113 HEARTWOOD DR. SALISBURY, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Measles-Hoffman Disease</u>								3 mo
DUE TO, OR AS A CONSEQUENCE OF (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/4</u> , 19 <u>68</u> , to <u>11/4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
D. S. Cinderson, M.D.		11/4/68		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		11/6/68		ALL SAINTS CEMETERY		WILMINGTON, NC., DELAWARE		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE		
Robert J. McQuay, Jr. 2200 Washington St. Wilm. Del.		NOV 12 1968		J. Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16634

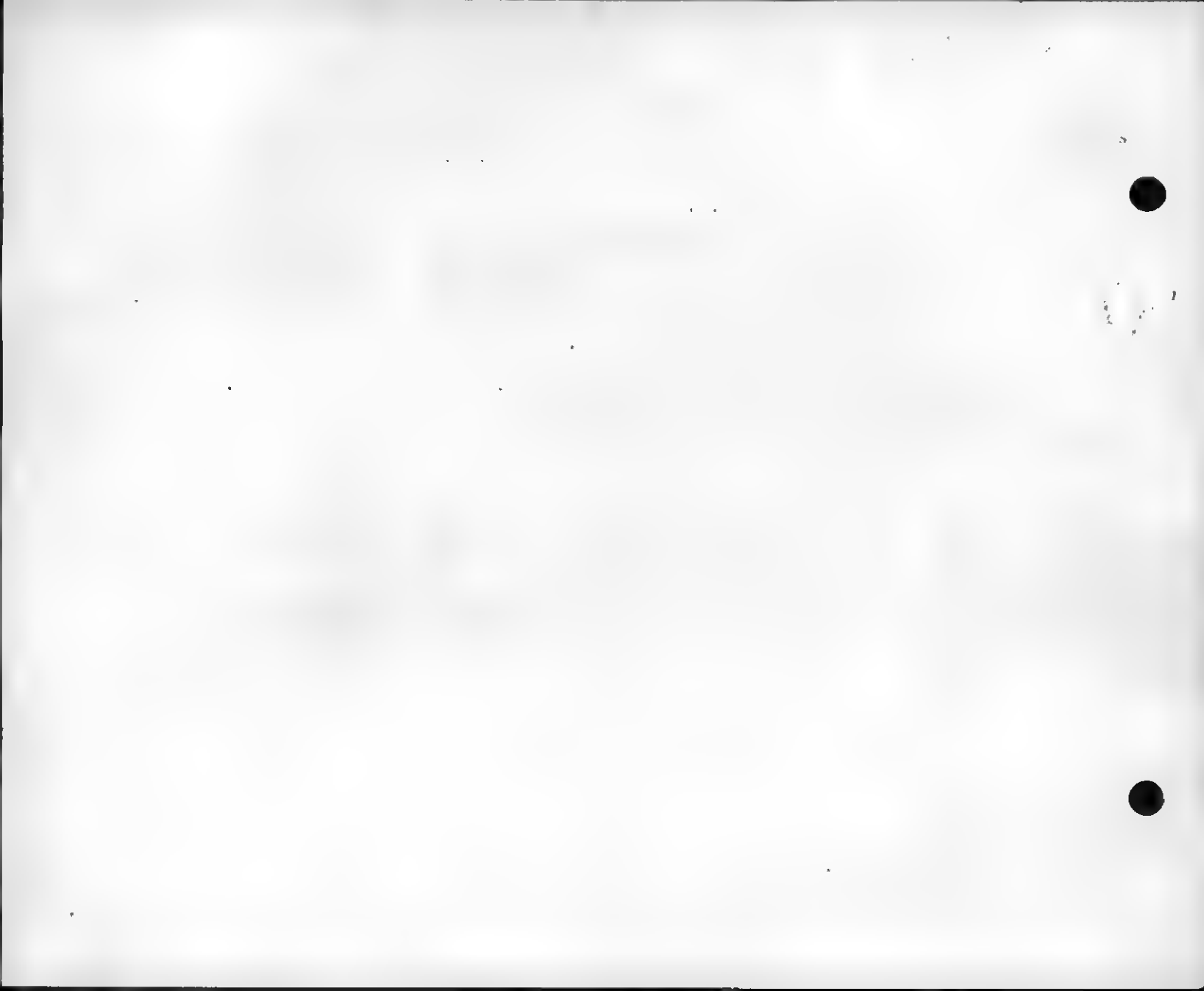
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Baby		Girl	Franklin		November 13 1968		10 58 P	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	White		11-13-1968		0 YRS. 0 0 0			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U.S.A.				Wicomico Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital		None		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Wicomico		Salisbury				107 Clemwood St.,
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
First Middle Last			First Middle Last					
Brady Lee Franklin, Jr.			Nancy Hurley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No			None		Mr. Brady Lee Franklin Jr. See Sec 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity (Birthwt 6.5 gm)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 hour</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
226x								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cert. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> 19 <u>68</u> , to <u>11/13</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/13</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Alfred C. Kolls MD</u>				22c. DATE SIGNED <u>11/13/68</u>		22d. PHYSICIAN'S NAME (Type) Dr. Alfred C. Kolls		
22e. ADDRESS <u>Medical Center Salisbury, Maryland</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		11-15-1968		Wicomico Memorial Park		Salisbury, Wicomico, Md.		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hill Funeral Home Salisbury, Maryland				NOV 18 1968		<u>Charles Judge</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

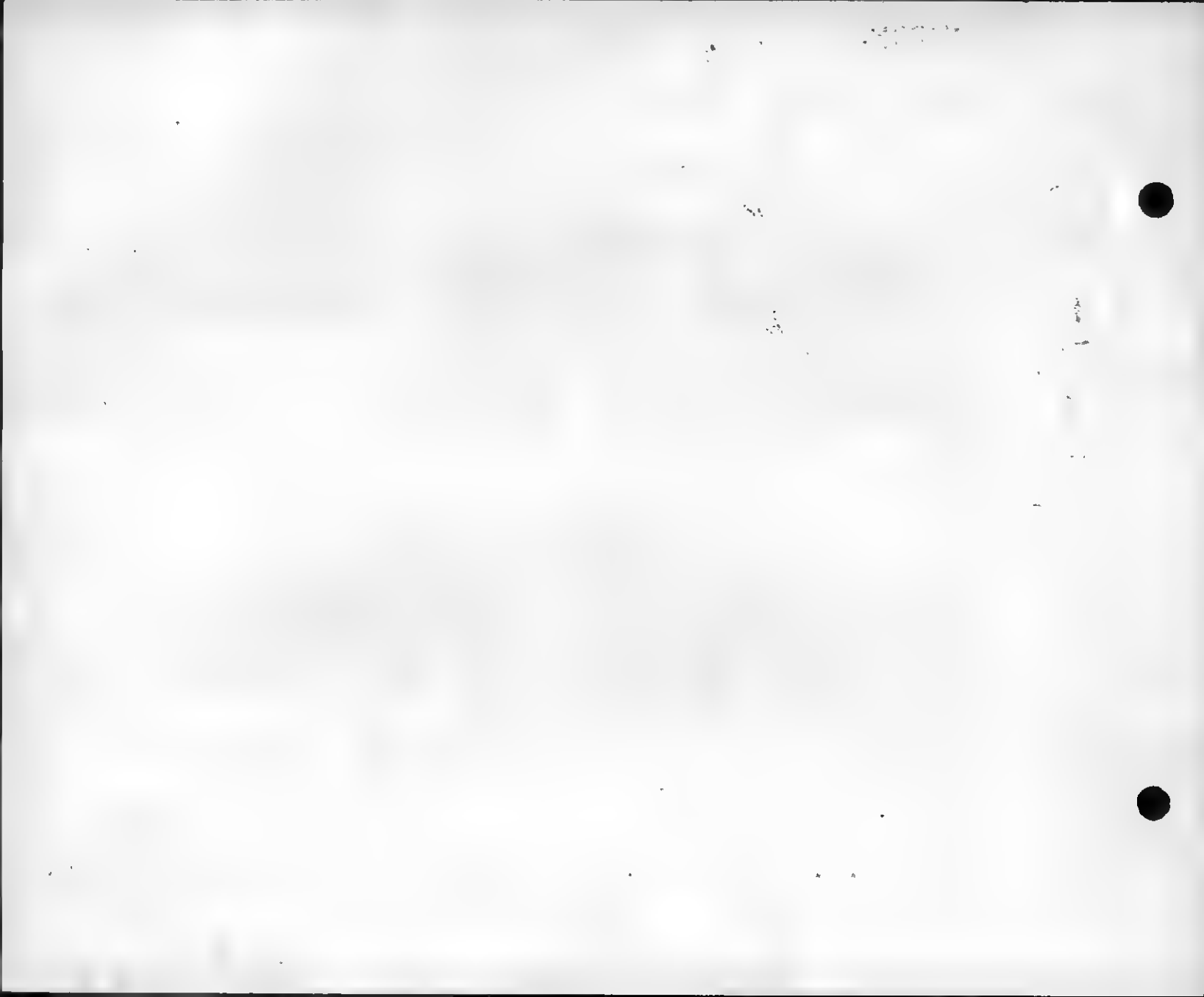


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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
LEROY			(None)		GODWIN		November 12, 1968		26 HOUR 11:15 AM		
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		White		Oct. 25, 1894			74 YRS				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Md.			USA				WICOMICO Md.				
1d CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Deer's Head State Hospital			Produce Dealer			Produce		
13a USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d HOUSE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Wicomico		Salisbury		YES		515 Wailles Street		
14 FATHER'S NAME First Middle Last			15. MOTHER'S M A D E R N NAME First Middle Last								
George Godwin			Anna Cantwell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT						
No					Mrs. Margie Godwin 515 Wailles Street Salisbury, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema (years) and bronchial pneumonia (days)</u> <u>472X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>5271</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>volvulus</u> <u>Squamous cell carcinoma of the right neck with extension to the hypopharynx and</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>October 21, 1968</u> , to <u>November 12, 1968</u> , that (X) (we) last saw the deceased alive on <u>November 12, 1968</u> , and that in (MY) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. C. Mitchell</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>11/12/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>						22e. ADDRESS <u>Deer's Head State Hospital, Salisbury,</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>			<u>11-15-68</u>		<u>Melsons Cemetery</u>		<u>Melsons, Wicomico, Md.</u>				
24 FUNERAL DIRECTOR <u>Thomas F. Wallace</u>						25 REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			
<u>Salisbury, Md.</u>						DATE <u>NOV 14 1968</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16638

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16650

1 DECEASED-NAME (Type or print)		First Middle Last		2a DATE OF DEATH		2b HOUR	
RILEY		DANIEL GREEN		November 5 1968		5 Day Year 1968 7:45 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male	White	April 12, 1899		69 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland	USA			WICOMICO Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital		Produce Dealer		Produce	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
Maryland		Wicomico	Delmar		R.D.3, Waller Road		
14. FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last					
Alexander Hamilton Green		Verma Della Bloodsworth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT (Wife) R.D.3 Address Waller Road			
No		213-22-8977		Mrs. Emma G. Green, Delmar, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u> <u>492x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic Obstructive Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Bronchial Asthma</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>Nov 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Thomas C. Hill, Jr. MD</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED November 7 / 1968	
22d. PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill, Jr.				22e. ADDRESS S. Salisbury Blvd., Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Nov. 8, 1968		Wicomico Memorial Park		Salisbury, Wicomico, Maryland	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HOLLOWAY & COMPANY, SALISBURY, MARYLAND				DATE NOV 12 1968		<u>Charles Judge</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

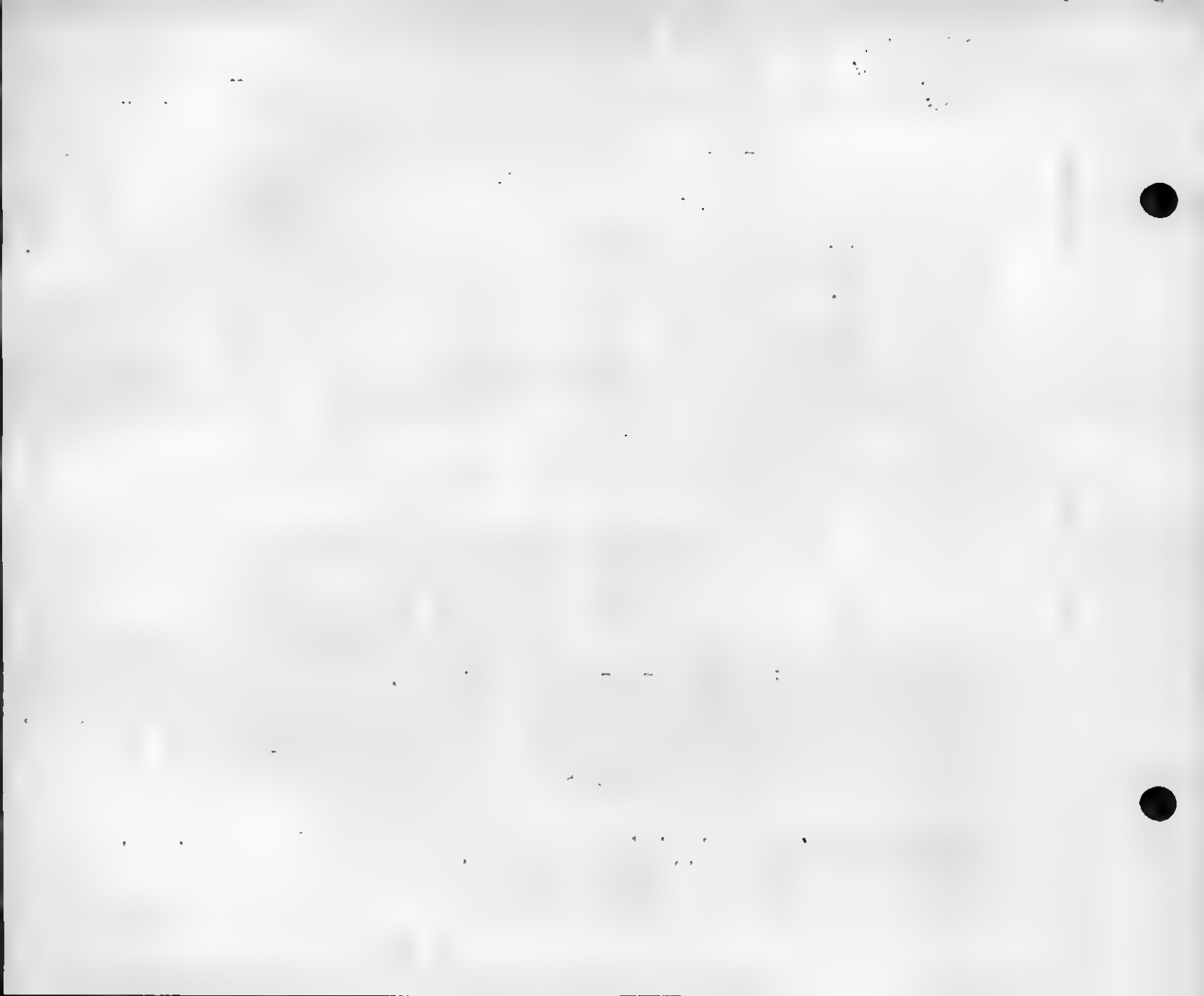
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16637

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1035.

1 DECEASED NAME (Type or Print) First Middle Last CLINTON ALFRED HARMON			2a DATE KNOWN OF DEATH Month Day Year 11-17-68			2b HOUR OF DEATH 3:15 P
3 SEX Male	4 RACE AA	5 DATE OF BIRTH 9-21-41	6 AGE (in years last birthday) 27 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	7c DATE PRONOUNCED DEAD Month Day Year 11 17 1968	2d HOUR OF DEATH 3:15 P
7a BIRTHPLACE (State or foreign country) Salisbury		7b CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Peninsula General		12a OCCUPATION (Kind of work done during most of working life, even if retired) Service sta.		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME First Middle Last Clinton J. Harmon		15 MOTHER'S MAIDEN NAME First Middle Last Sarah Jones		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (1 yes give war or dates of service)		
16b SOCIAL SECURITY NO.		17 INFORMANT'S NAME AND ADDRESS Shirley Harmon 1114 E. 1st St. Salisbury, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture of cervical spine 517.0 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 3:05 PM 11-17-68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, item 18) Driver of auto involved in 1 vehicle accident.		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) road		21f LOCATION Street or R.F.D. No City or Town County State Jersey Road, Salisbury, Wicomico, Md.		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Earl L. Royer, M.D.		EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED Nov. 19, 1968
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE 11-23-68		23c NAME OF CEMETERY OR CREMATORY Head of the Creek		23d LOCATION (City or Town) (County) (State) Quantico Wic Md.
24 FUNERAL DIRECTOR Jolley Funeral Home, Salisbury, Md.				25a RECD BY REGISTRAR DATE NOV 22 1968		25b REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) CARLton William Hastings			2a. DATE OF DEATH Month November Day 12 Year 1968			2b. HOUR 8 MIN 45	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH October 5, 1894		6. AGE (in years last birthday) 74 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Ice Company	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER R.D.6, Harford Road							
14. FATHER'S NAME First John Middle E. Last Hastings				15. MOTHER'S MAIDEN NAME First Katie Middle B. Last Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go on, or unknown) No (If give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife) R.D.6 Address Harford Road Mrs. Agnes G. Hastings, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Lung + Right 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1621							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/3 1968 , to 10/9 1968 , that (I) (we) last saw the deceased alive on 10/9/68 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William B. Long				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/12/68	
22d. PHYSICIAN'S NAME (Type) William B. Long				22e. ADDRESS SALISBURY, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 14, 1968		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland	
24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DATE NOV 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE HEALTH DEPT.

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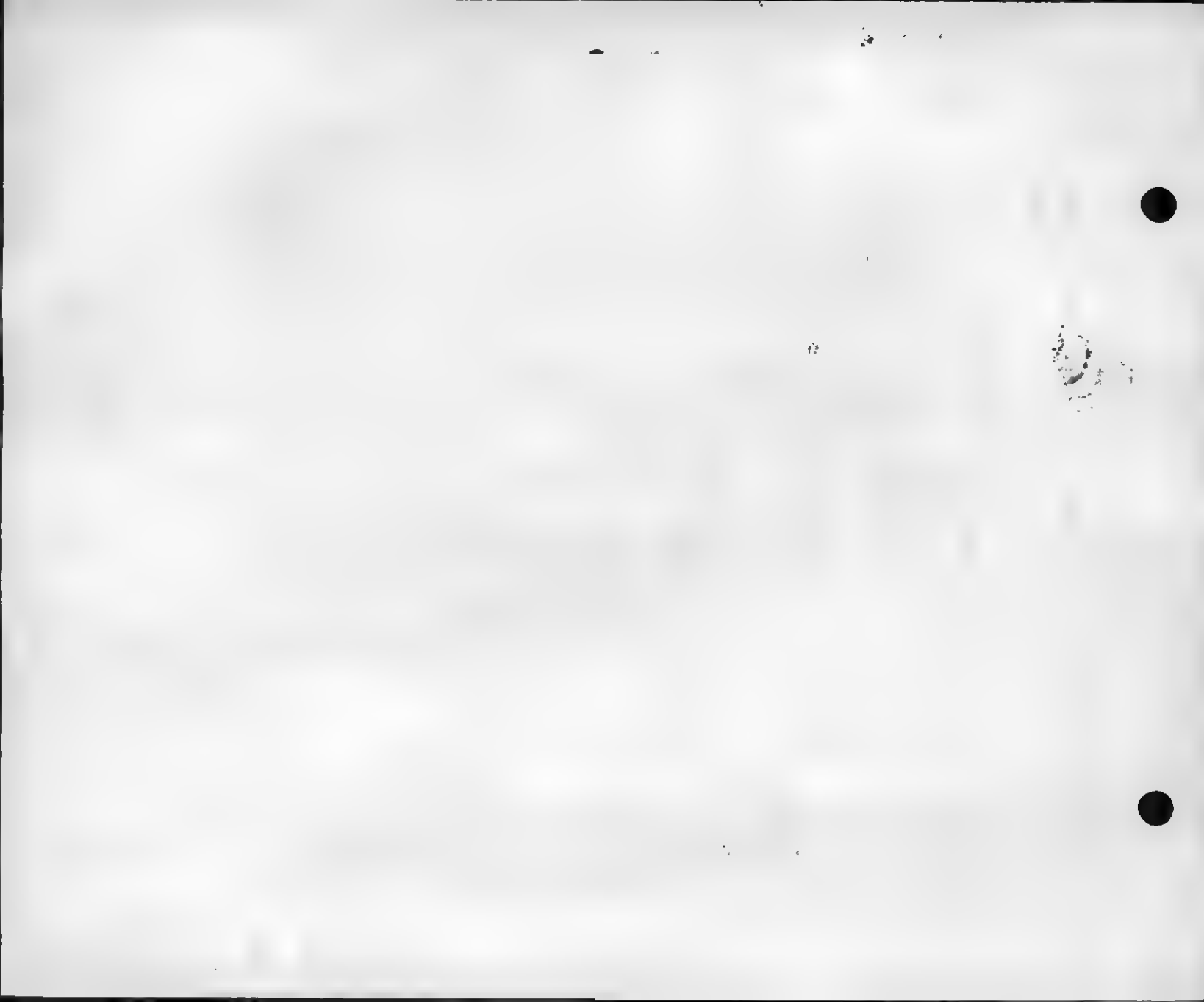
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16639

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1667

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR			
JAMES FRANKLIN HASTINGS						Month Day Year 11/21 1968			M			
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 24 HRS	8. MONTHS	9. DAYS	10. HOURS	11. MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	July 17, 1915	53 YRS						Month Day Year November 21 1968			M
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			WICOMICO			Md
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury			Peninsula General Hospital			Route Salesman			Dry Cleaning			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER
Maryland			Wicomico			Hebron			YES <input type="checkbox"/> NO <input type="checkbox"/>			Box 3, Church Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT (Wife) ADDRESS
Edgar Hastings			Mable Hayman			Yes (If yes give war or dates of service) War II			219-03-0014			Church Street
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			CHIEF MED. CAL. EXAMINER <input type="checkbox"/>			ASS. STANT MED. CAL. EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street city, town or county)			November 23 / 1968			
Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Nov. 24, 1968			St. Johns Cemetery			Fruitland, Wicomico, Maryland			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						DATE NOV 26 1968			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1 69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First ANDY		Middle LUE		Last HAYWARD		2a DATE OF DEATH Month November Day 7 , Year 1968		2b HOJR 3:05A M	
3. SEX Female		4 RACE Colored		5. DATE OF BIRTH May 7, 1899		6 AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO		12b KIND OF BUSINESS OR INDUSTRY Domestic		Md	
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Maids		12b KIND OF BUSINESS OR INDUSTRY Domestic					
13a USUAL RESIDENCE (Where deceased lived, if not in an residence before admission) STATE Maryland		13b COUNTY Worcester		13c CITY OR TOWN Snow Hill		13d INSIDE CITY (Y/N) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Rt. #1			
14 FATHER'S NAME First John		Middle Hudson		Last Hudson		15 MOTHER'S MAIDEN NAME First Mary		Middle Jackson		Last Jackson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NA		(If yes give war or dates of service)		16b SOCIAL SECURITY NO 055 18 9723		17 INFORMANT Arthur F. Hayward, Snow Hill, Md.		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (b) Phlebitis - pelvic veins DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of the thyroid gland										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH --	
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from October 23, 1968 , to November 7, 1968 , that (X) (we) last saw the deceased alive on November 7, 1968 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.											
22b SIGNATURE L. V. Maldve, M. D.		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/7/68					
22a PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22e ADDRESS Deer's Head State Hospital, Salisbury,									
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE Nov. 9, 1968		23c NAME OF CEMETERY Coolspring Meth.		23d LOCATION (City or Town) (County) (State) Snow Hill, Maryland					
24 FUNERAL DIRECTOR Arthur F. Hayward, Snow Hill, Md.		ADDRESS		25a REC'D BY REGISTRAR NOV 12 1968		25b REGISTRAR'S SIGNATURE Charles Judge					



Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 123

16641 Item Film # 08 1/6/69 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										10375			
1 DECEASED NAME (Type or print) Russell				First Lee		Middle Hayward Jr.		Last Jr.		2a DATE OF DEATH Month November Day 22 Year 1968				2b HOUR 12:30 PM	
3 SEX male		4 RACE Negro		5 DATE OF BIRTH Apr. 22, 1968				6 AGE (n years last birthday) 6 YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico									
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) None				12b KIND OF BUSINESS OR INDUSTRY -					
3a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Worcester Pocomoke		13c INSIDE CITY, M IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13a STREET AND NUMBER Route I Br. 226									
14 FATHER'S NAME First Russell Middle Hayward Jr. Last Ollie				15 MOTHER'S MAIDEN NAME First Beasley Middle Beasley Last Beasley											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown No		16b SOCIAL SECURITY NO. None		17 INFORMANT Address Russell Hayward, Jr. Pocomoke Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia 485X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 49TX DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Mental and severe physical retardation due to microcephaly															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f LOCATION Street or RFD No City or Town County State											
22a I certify that (I) (this hospital) attended the deceased from 11/22, 1968 , to 11/22, 1968 , that (I) (we) lost the deceased on 11/22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (d) nat view the body after death															
22b SIGNATURE Alfred C. Koller				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 11/20/68							
22d PHYSICIAN'S NAME (Type) Samuel Savage				22e ADDRESS Medical Center Salisbury, Maryland											
23a BURIAL, CREMATORY, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)									
Burial		11-26-68		Tindley Chapel Cem. Pocomoke Wor. Md.		New Church, Va.									
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE									
Samuel Savage		New Church, Va.		NOV 27 1968		John Charles Judge									



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

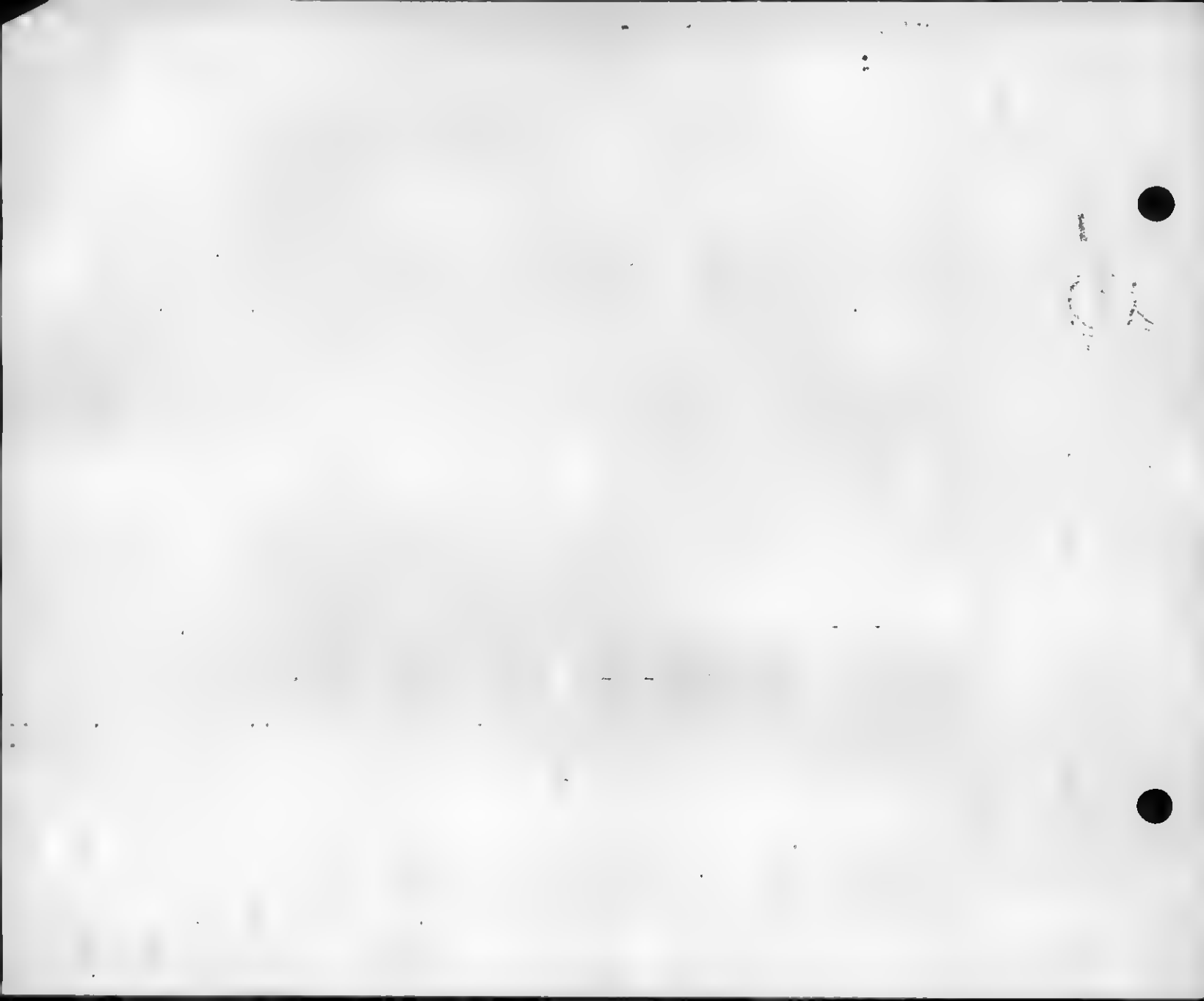
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16642

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1665

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b HOUR					
JAMES ROBERT HICKS						11/24 1968			1:30 A					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR			
Male	White	May 4, 1891	77 YRS					November 24 1968			1:30 A			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
Illinois			USA						WICOMICO			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			Retired Merchant								
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e STREET AND NUMBER		
Maryland			Wicomico			Salisbury						607 N. Pinehurst Ave.		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
James R. Hicks			Laticia Owens											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT (Wife)			ADDRESS					
No			822-01-0158			Mrs. Clara May Hicks			607 N. Pinehurst Ave. Salisbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fractured neck of left femur</u>														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY?								
11-12-68			Fractured neck of left femur.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year HOUR A.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			11-10-68			Fell at own home.								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State								
			own home			607 N. Pinehurst Ave., Salisbury, Wic., Md.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
			Earl L. Royer, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						November 26 / 1968		
			409 Camden Ave., Salisbury, Md.			ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			Nov. 26, 1968			Wicomico Memorial Park			Salisbury, Wicomico, Maryland					
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						DEC 2 1968								



16643

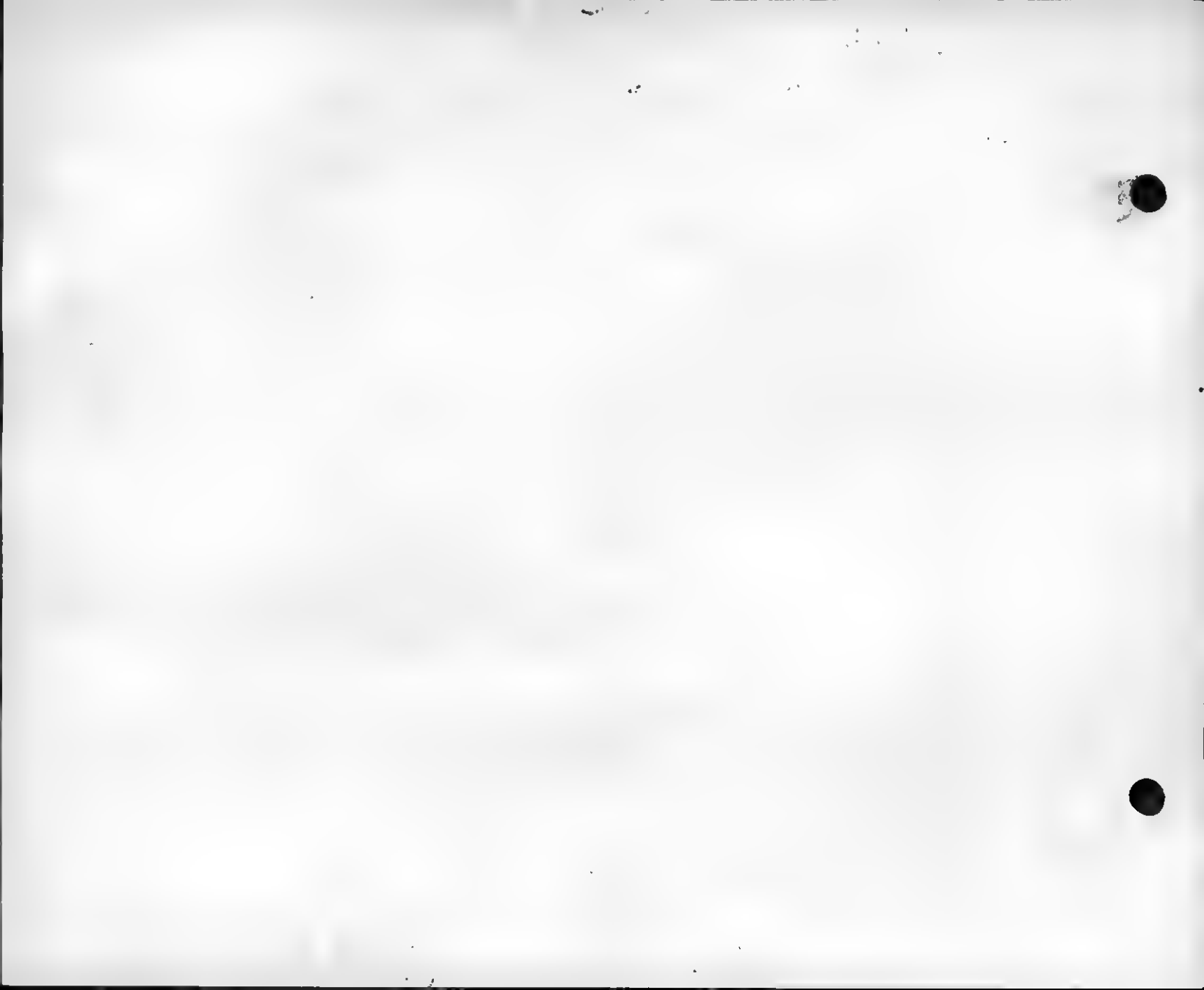
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
WILLIAM FRANCIS Hiebendahl					November 4 1968		7 ¹⁰ P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		May 16, 1901		67 YRS.		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
New York		USA				Wicomico Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital		Engineer (Boiler)		----		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		R.D.1, Upper Ferry Road
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Edward		Hiebendahl		Alice Myer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown) <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT (Wife) R.D.1 Address Upper Ferry Road				
		081-07-5864-A		Mrs. Marie Hiebendahl, Salisbury, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u>								
DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Rheumatic Heart Disease with Auricular</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Fibrillation and Congestive Failure</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
416x								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Oct 16, 1968, to Nov 4, 1968, that (I) (we) last saw the deceased alive on Nov 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE		22c. DATE SIGNED						
Thomas C. Hill, Jr. M.D.		11-4-68						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Dr. Thomas C. Hill, Jr.		Pine Bluff Rd. Salisbury, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Nov. 7, 1968		Wicomico Memorial Park		Salisbury, Wicomico, Maryland		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
HOLLOWAY & COMPANY, SALISBURY, MARYLAND		NOV 8 1968		Charles Judge				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

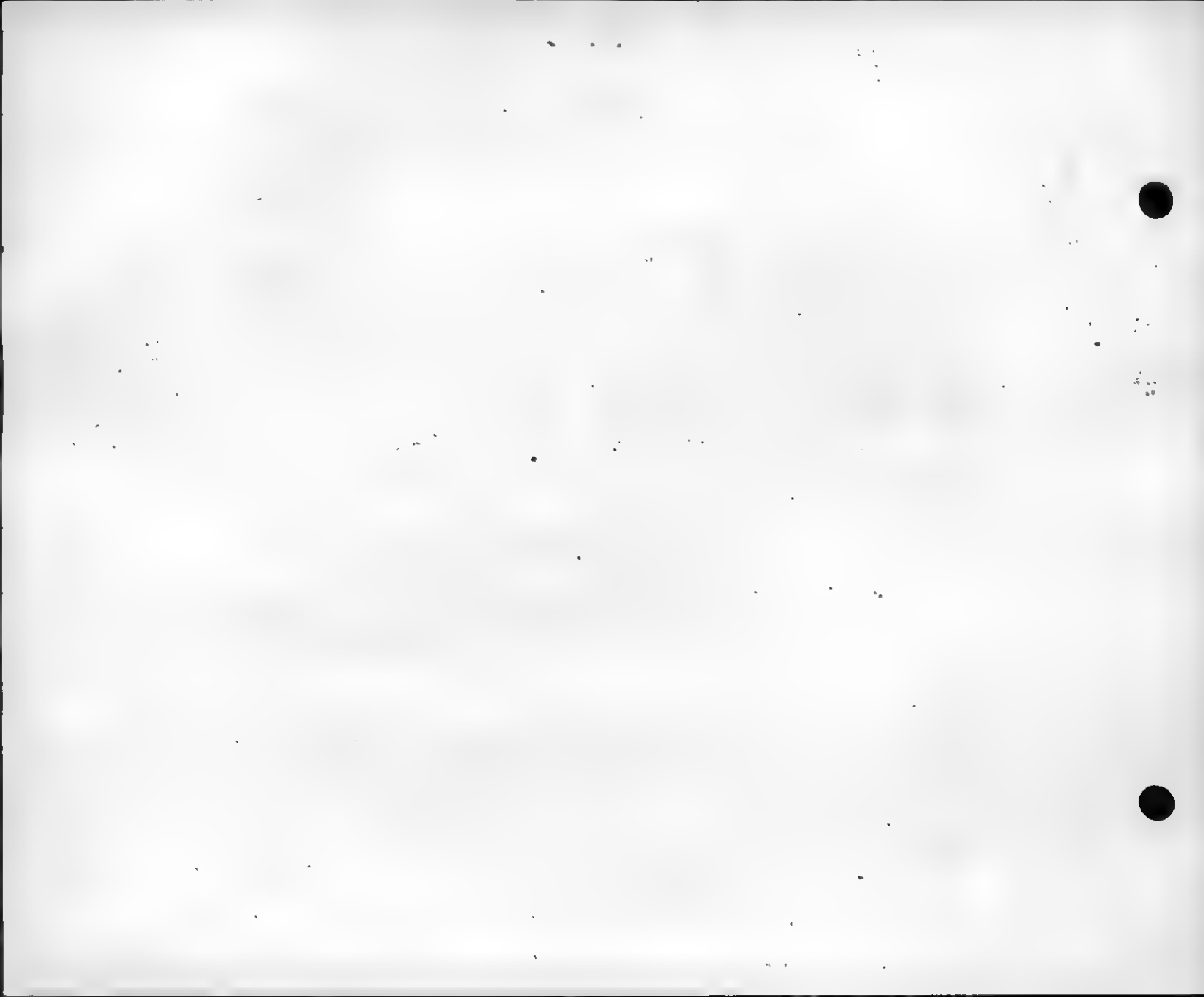


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 155
30A REV 1/68

<div style="display: flex; justify-content: space-between;"> 16644 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16654 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
JAMES			ARTHUR			INSLEY			November 21 1968 6 P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Male		White		September 6, 1889			79 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				WICOMICO Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Waterman			---		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Wicomico		Salisbury				203 E. Locust Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Samuel Hix Insley			Alexine Collins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT (Wife)			Address			
No			227-01-4542		Mrs. Sadie M. Insley, Salisbury, Maryland			203 E. Locust St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>arterial hemorrhage</i>											<i>1 day</i>
431.4 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<i>Generalized arteriosclerosis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/13/68</i> to <i>11/21/68</i> , that (I) (we) last saw the deceased alive on <i>10/13/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dr. F.M. Beardsley</i>								22c. DATE SIGNED		November 24 1968	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS			
Dr. F.M. Beardsley								211 Maryland Ave., Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Nov. 23, 1968		Wicomico Memorial Park		Salisbury, Wicomico, Maryland					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						NOV 25 1968		<i>Johnnie Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

Item 7 Film 07 12/3/68
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1665

1 DECEASED-NAME (Type or print) ANNIE		First	Middle	Last	2a DATE OF DEATH Month November Day 9 Year 1968		2b HOUR 2:00AM		
3 SEX Female		4 RACE Colored		5. DATE OF BIRTH 12/15/03		6 AGE (in years lost birthday) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WICOMICO		Md	
10. CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INST LIT ON (If not a hospital give street address) Deer's Head State Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Dorchester		13c CITY OR TOWN Cambridge		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 804 Pine Street	
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or, unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO 224-16-3552		17 INFORMANT Deer's Head State Hospital Records,		Address Salisbury, Md. 21801	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (If either, notify medical examiner) stating the underlying cause lost. (b) Hypertensive arteriosclerotic cardiovascular disease, decompensated. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic pyelonephritis									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State					
22a I certify that (A) (this hospital) attended the deceased from February 28, 1967 , to November 9, 1968 , that (A) (we) last saw the deceased alive on November 9, 1968 and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (we) (did) (did not) view the body after death									
22b SIGNATURE L. V. Maldve, M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 11/11/68			
22d PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22e ADDRESS Deer's Head State Hospital, Salisbury,							
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE 11-18-68		23c NAME OF CEMETERY OR CREMATORY Deer's Head		23d LOCATION (City or Town) (County) (State) Salisbury Md.			
24 FUNERAL DIRECTOR Looper M. W.		ADDRESS		25a REC'D BY REGISTRAR DATE NOV 20 1968		25b REGISTRAR'S SIGNATURE James J. Judge			



From birth cert.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16646

16646

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Baby Lawrence S. JOHNSON			2a. DATE OF DEATH Month NOVEMBER Day 18 Year 1968			2b. HOUR 11:19 PM							
3. SEX MALE		4. RACE Colored		5. DATE OF BIRTH II/13/68		6. AGE (In years last birthday) 1 YRS.		IF UNDER 1 YEAR MONTHS 1 DAYS 12		IF UNDER 24 HRS. HOURS 11 MIN. 19			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico			Md				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp ital give street address) Peninsula General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Somerset			13c. CITY OR TOWN Manokin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 52			
14. FATHER'S NAME First Laurance Middle Maddox Last Alfreta Johnson			15. MOTHER'S MAIDEN NAME First Alfreta Johnson Middle Alfreta Johnson Last Alfreta Johnson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Alfreta Johnson, Manokin, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. N. S. hemorrhage 7762 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hr.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1710 C. Section Delivery -> Rupt. Distension Syndrome													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11/18 , 1968, to 11/18 , 1968, that (I) (we) last saw the deceased alive on 11/18 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE D. S. Anderson			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 11/19/68				
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE II/21/68			23c. NAME OF CEMETERY OR CREMATORY Samuel Wesley			23d. LOCATION (City or Town) (County) (State) Manokin, Maryland				
24. FUNERAL DIRECTOR William H. James Jr			ADDRESS Princess Anne, Md			25a. REC'D BY REGISTRAR NOV 25 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16647

CERTIFICATE OF DEATH

16651

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> c. LENGTH OF STAY IN TB <u>All Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> d. STREET ADDRESS <u>P.O.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARTHA ELIZABETH JOHNSON</u> First Middle Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAR 24, 1896</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>72 yrs</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Fruitland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				4. DATE OF DEATH <u>November 30 1968</u> Month Day Year 13. FATHER'S NAME <u>UNKNOWN</u> 14. MOTHER'S MAIDEN NAME <u>MARY SHOCKLEY</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO <u>220-10-8284</u> 17. INFORMANT <u>ROGER JOHNSON</u> Address <u>FRUITLAND P.O. MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>1968</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				19. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> 20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>201X</u> 21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19 1968</u> to <u>Nov 30 1968</u> that (I) (we) last saw the deceased alive on <u>Nov 30 1968</u> and that death occurred at <u>7:00 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>10/1/68</u> 22c. PHYSICIAN'S NAME (Type) <u>E. A. Farnell, MD.</u> 22d. ADDRESS <u>6520 Main St, Fruitland, Md.</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>12-7-68</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u> 23d. LOCATION (City or Town) (County) (State) <u>Fruitland Wicomico Md.</u>			
24. FUNERAL DIRECTOR <u>Charles B. Jolley</u> 25a. REC'D BY REGISTRAR <u>DEC 12 1968</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> Address <u>Jerry St. #2, Salisbury, Md.</u>							



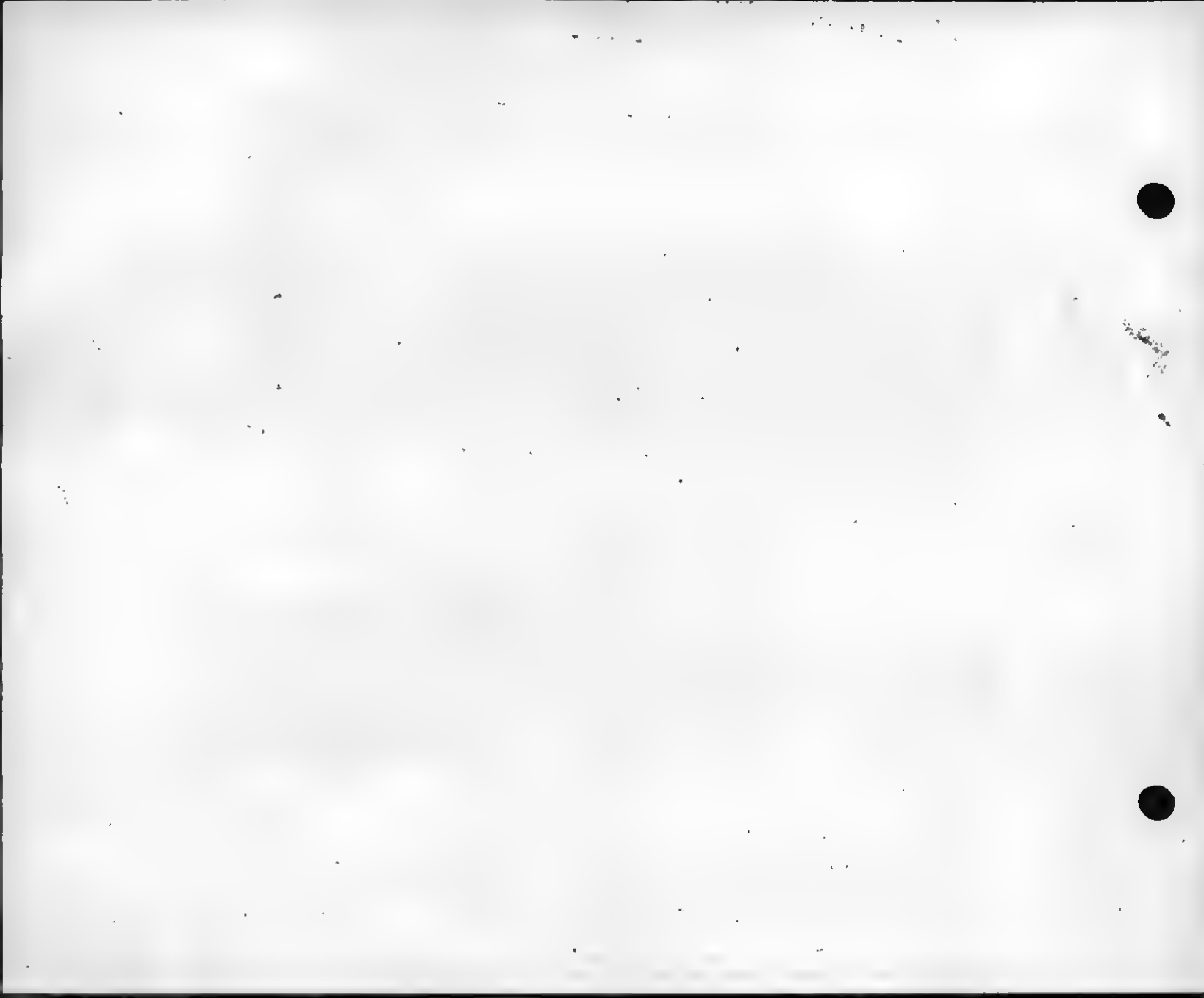
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16648

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 391 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR M		
BERTHA			BLANCHE			KELLEY			November 21 1968		
3 SEX Female			4 RACE White			5. DATE OF BIRTH June 20, 1878			6 AGE (In years last birthday) 90 YRS		
7a. BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH WICOMICO Md.		
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 315 Park Avenue			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY ---		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Wicomico			13c CITY OR TOWN Salisbury			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 315 Park Avenue			14. FATHER'S NAME First Middle Last John T. Pope			15. MOTHER'S MAIDEN NAME First Middle Last Truscilla L. Pusey					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown] (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 217-54-5373			17 INFORMANT (Son) Mr. Guy C. Kelley, Salisbury, Maryland			R.D. 5 Address Pemberton Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 436.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 min. 10 yr.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 17, 1968</u> , to <u>Nov 21, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Frank L. Weaver</u> 22c. PHYSICIAN'S NAME (Type) Dr. Frank L. Weaver			22d. ADDRESS Salisbury, Maryland			22e. DATE SIGNED November 22, 1968					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov. 24, 1968			23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR DATE NOV 25 1968			25b. REGISTRAR'S SIGNATURE <u>John Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

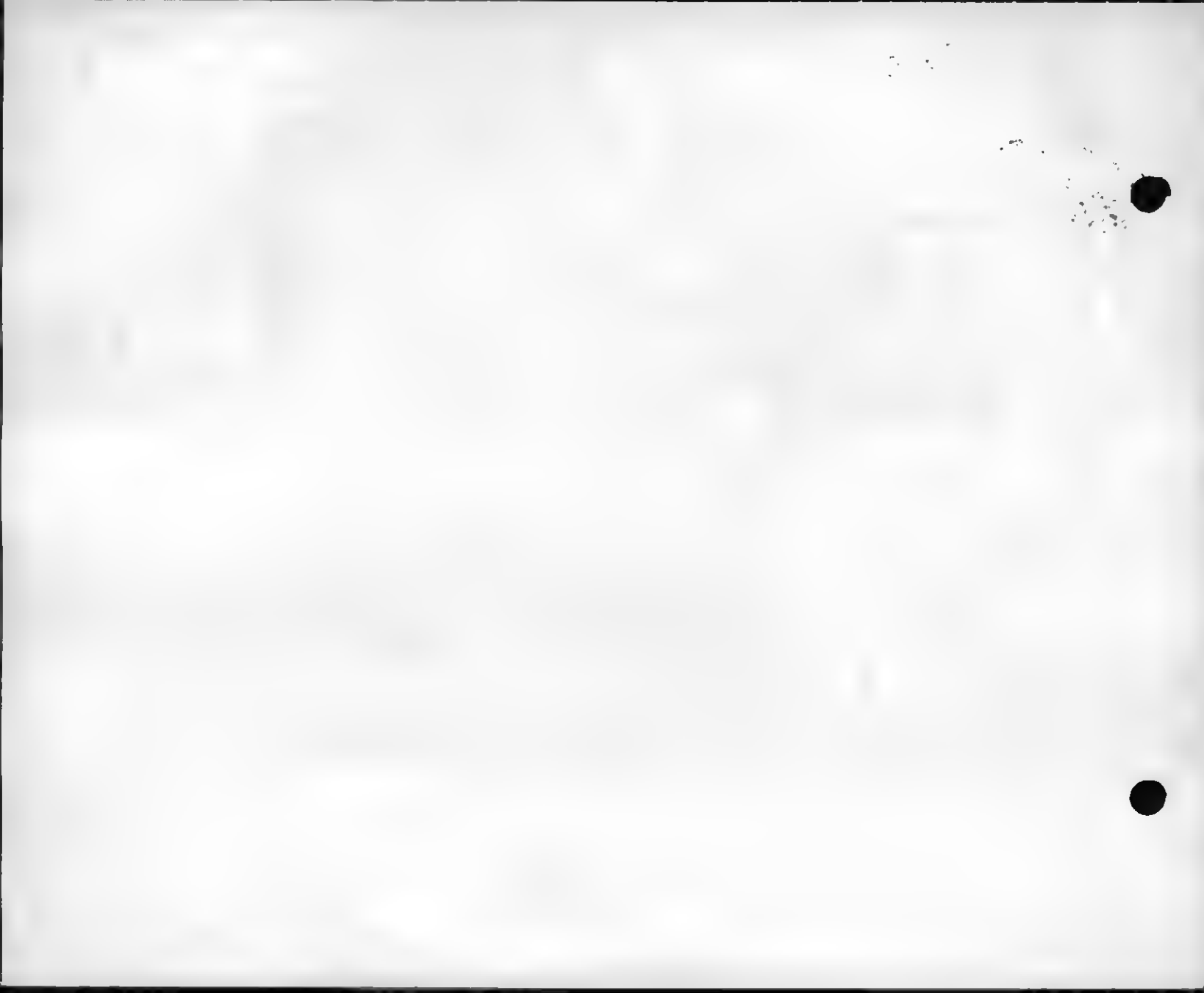
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
304 REV. 1960

1
16649
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1668

1 DECEASED-NAME (Type or print) First Middle Last ANNA C. KING			2a. DATE OF DEATH Month Day Year November 17 1968			2b. HOUR MIN 9 43	
3 SEX F		4. RACE W		5. DATE OF BIRTH AUG. 15, 1900		6 AGE (In years last birthday) 68 YRS	
7a. BIRTHPLACE (State or foreign country) Pittila PA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md	
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY SELF EMP.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY WICOMICO		13c. CITY OR TOWN BERLIN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER MAIN ST.		14. FATHER'S NAME First Middle Last JACOB KARSLEY		15. MOTHER'S MAIDEN NAME First Middle Last JOSEPHINE CUBB			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO (If no, give war or dates of service) 209-14-6960		17 INFORMANT Address MRS. ORLANDO PITILLIPS OGAN CITY MD			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic cholestasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 525X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>68</u> , to <u>11-17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>E Kent Carney</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-19-68	
22d. PHYSICIAN'S NAME (Type) E KENT CARNEY		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/21/68		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WICOMICO MD	
24. FUNERAL DIRECTOR Anne A. Burbage		ADDRESS Berlin Md		25a. RECD BY REGISTRAR DATE NOV 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print) ANNE			First ROCHEFORT			Middle			Last Lamy			2a. DATE OF DEATH Month November Day 27 Year 1968			2b. HOUR 4 P M		
3 SEX Female			4 RACE White			5 DATE OF BIRTH June 8, 1920			6 AGE (in years) 48			7 UNDER 1 YEAR MONTHS			8 UNDER 24 HRS HOURS M.N.		
7a BIRTHPLACE (State or foreign) Rhode Island			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Wicomico			Md					
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			12a USUAL OCCUPATION (Kind of work done during most of whole year) housewife			12b KIND OF BUSINESS OR INDUSTRY own home								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Wicomico			13c CITY OR TOWN Salisbury			3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3e STREET AND NUMBER 517 Druid Hill Ave.					
14 FATHER'S NAME First Charles			Middle ROCHEFORT			Last			15 MOTHER'S M.A.DEN NAME First Mary			Middle MACK			Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b SOCIAL SECURITY NO (If yes give war or dates of service) 036 09 5531			17 INFORMANT Joseph A. Lamy			Address see sec. # 13								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia												24 hr.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF Cachexia												4 weeks.					
DUE TO, OR AS A CONSEQUENCE OF Abdominal aortic aneurysm rupture												18 mos.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1965 to 11/27, 1968, that (I) (we) last saw the deceased alive on 11/27/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Stedman W. Little			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 11-28-68								
22d. PHYSICIAN'S NAME (Type) Tedman W. Smith			22e. ADDRESS Camden Ave; Salisbury, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/3/1968			23c. NAME OF CEMETERY OR CREMATORY St. Columba Cemetery			23d. LOCATION (City or Town) (County) (State) Portsmouth Newport R.I.								
24. FUNERAL DIRECTOR Hill Funeral Home			ADDRESS Salisbury, Maryland			25a. REC'D BY REGISTRAR DEC 2 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16651

1666.

1 DECEASED-NAME (Type or print) MARY PEARL LAWSON			2a. DATE OF DEATH Month NOVEMBER Day 4 Year 1968			2b. HOUR 4:45 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH SEPT-16-1891		6. AGE (In years last birthday) 77 YRS	
7a. BIRTH-PLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEHOLD		12b. KIND OF BUSINESS OR INDUSTRY HOUSEHOLD	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY SOMERSET		13c. CITY OR TOWN CRISFIELD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER ---		14. FATHER'S NAME First JAMES Middle SCOTT Last MELISSA		15. MOTHER'S MAIDEN NAME First DIZE Middle --- Last ---			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO UNKNOWN		17. INFORMANT HAROLD LAWSON - CRISFIELD - MD		Address ---	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pancreatitis 510X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Cholecystitis DUE TO, OR AS A CONSEQUENCE OF (c) ---							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48hrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 585X Arterio-sclerotic cardiovascular disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-3 , 19 68 , to 11-4 , 19 68 , that (I) (we) last saw the deceased alive on 11-4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE [Signature]						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) [Signature]						22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE NOV 7-1968		23c. NAME OF CEMETERY OR CREMATORY SUNNYRIDGE PARK		23d. LOCATION (City or Town) (County) (State) HOPEWELL SOM MD	
24. FUNERAL DIRECTOR HERMAN WEBSTER				25a. REC'D BY REG. STR. DATE NOV 14 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



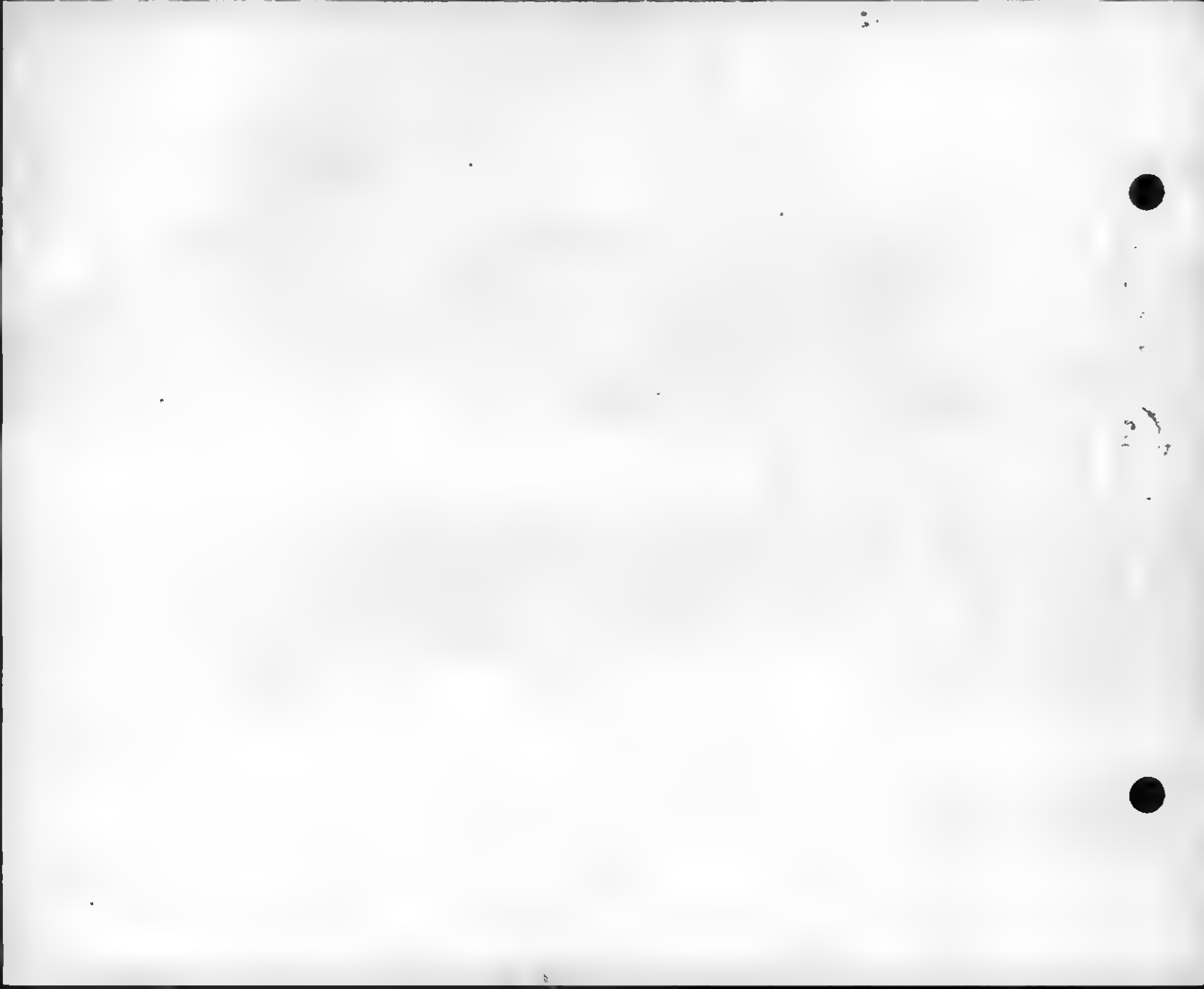
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-68
30M REV 1-68

<div>16652</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item #6, Film GL07 12/9/68 km</div> <div>CERTIFICATE OF DEATH</div> <div>16660</div>																	
1. DECEASED NAME (Type or print)			First			Middle			Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M		
Ray									LEWIS			NOVEMBER 30 1968			8 12 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
MALE			White			Dec. 2, 1891			77 1/2 YRS.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Willards, Md.			USA						Wicomico						Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Salisbury			Peninsula General Hospital			Farmer & Poultryman			Own Farm								
13a. USUAL RESIDENCE (Where deceased lived, if institution- admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Wicomico			Willards			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			XX					
14. FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME			First Middle Last		
Myer Lewis												Henretta Parker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address								
Yes			World # 1			220-34-7536			Agnes Lewis			Willards, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18da.</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>42</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>11-12</u> , 19 <u>68</u> , to <u>11-30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-30</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED								
Willard R. Ellis									11-30-68								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
Burial			12/3/68			New Hope			Willards			Wicomico			Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Peter Whaley			Selbyville, Del.			DEC 5 1968			John D. Jones								

MEDICAL CERTIFICATION



**FOR STATE
HEALTH DEPT.**

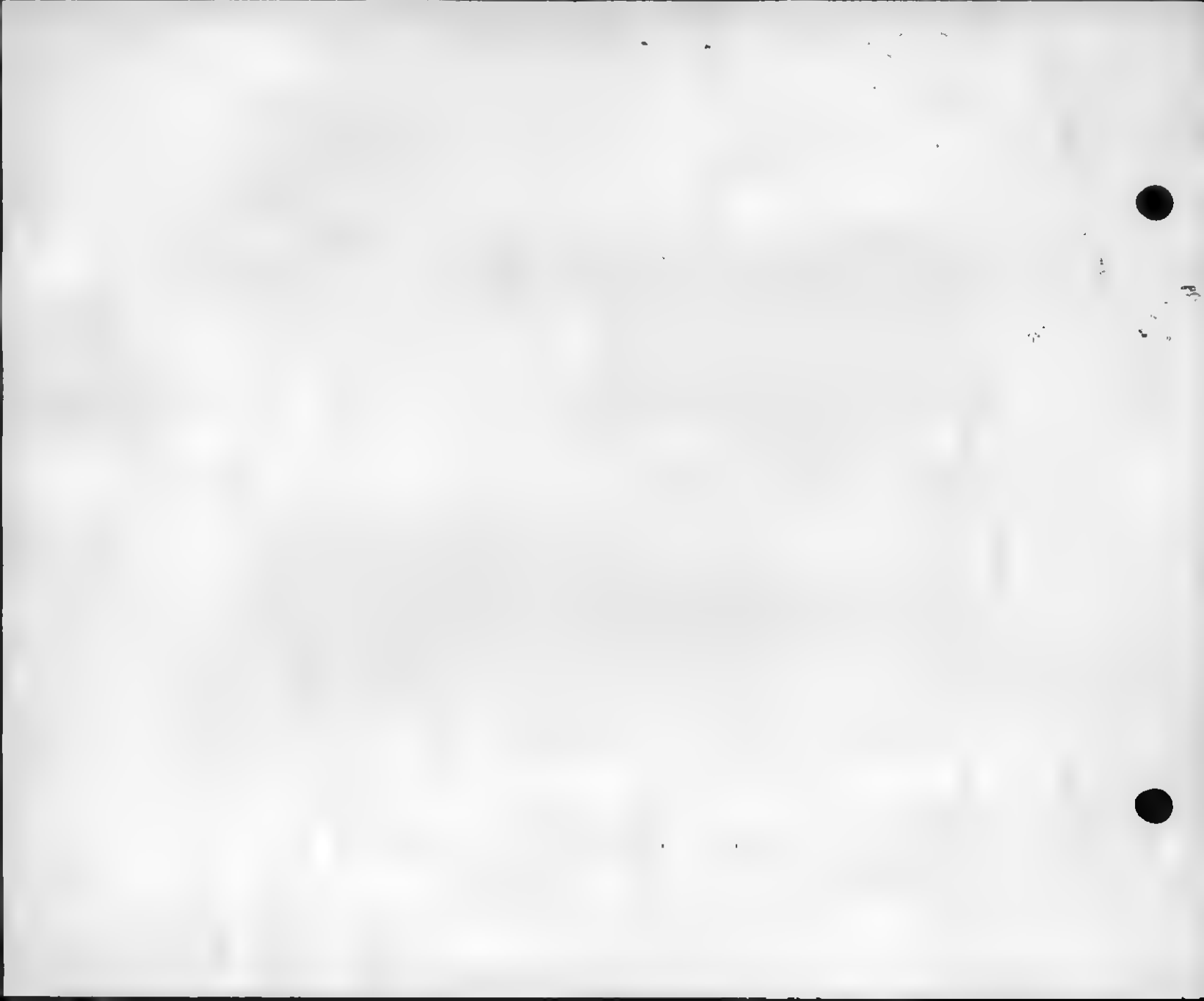
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

16653

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

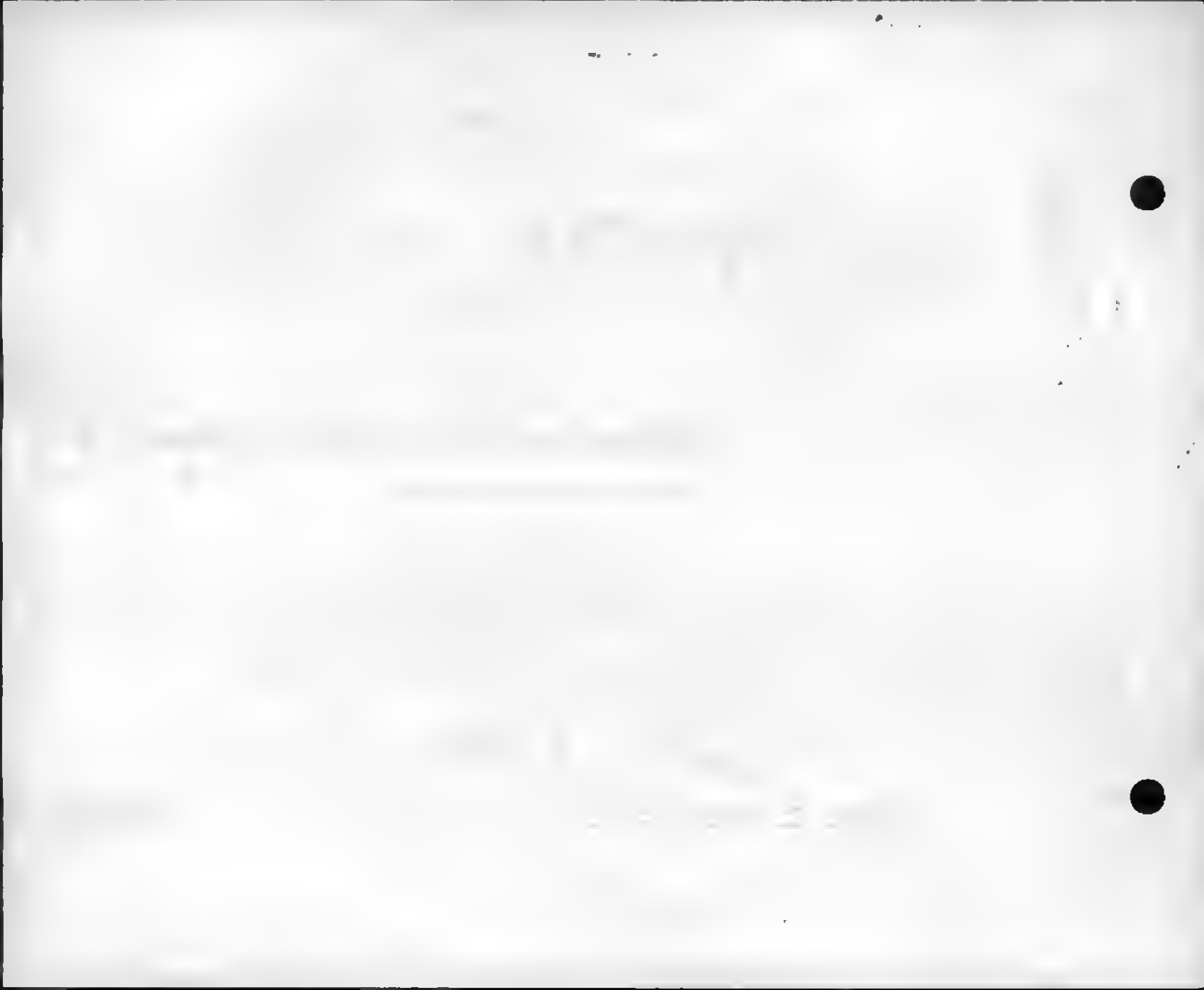
1. DECEASED NAME (Type or Print) First: ROY Middle: JAMES Last: LEWIS, SR.			20. DATE KNOWN OF ESTI-DEATH MATED Month: 11 Day: 12 Year: 1968			2b HOUR M				
3 SEX Male	4 RACE White	5 DATE OF BIRTH February 20, 1917	6 AGE (in years) 51 YRS	7 UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN:	8 IF UNDER 24 HRS MONTHS: DAYS: HOURS: MIN:	2c DATE PRONOUNCED DEAD Month: November Day: 12 Year: 1968			2d HOUR M	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO			Md	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 810 S. Division Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Service Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Scale Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland		13b. COUNTY: Wicomico		13c. CITY OR TOWN: Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 810 S. Division Street		
14. FATHER'S NAME First: Martin Middle: Lewis Last: Niblett			15. MOTHER'S MAIDEN NAME First: Carrie Middle: Niblett Last: Niblett			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				
16b. SOCIAL SECURITY NO 220-01-9519			17. INFORMANT (Wife) Mrs. Nellie F. Lewis, Salisbury, Maryland			ADDRESS: 810 S. Division St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 <i>Cerebral Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED November 14/1968				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 15, 1968		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR DATE NOV 15 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16654 CERTIFICATE OF DEATH 1656									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
DOROTHY			MADELINE			11-27-68			7:15 PM
3 SEX		4 RACE		5 DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
Female		WHITE		August 7, 1916			52 YRS		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Massachusetts		USA				Wicomico Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital			House wife		---	
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		519 Wicomico Street
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
George E. Murray			Gladys E. Stephenson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17. INFORMANT (Husband) Address				
No					Mr. Elmer F. Lord, Salisbury, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis, metastatic to brain & lungs									2 wks
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of ovary									2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
1726									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work									
22a. I certify that (I) (this hospital) attended the deceased from Sept 1968 to Nov 27, 1968, that (I) (we) last saw the deceased alive on Nov 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						MD DEGREE		22c. DATE SIGNED	
Alberta Mattax Polin								11/28/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
ALBERTA M. POLIN, M.D.						727 CAMDEN AVE, SALISBURY, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Nov. 30, 1968		Parsons Cemetery		Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						DEC 2 1968		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>16655</div> <div> <div>1</div> <div>16669</div> </div> <div> <div> <div>1</div> <div>16669</div> </div> <div> <div>16655</div> <div>16669</div> </div> </div>											
1 DECEASED-NAME (Type or print) Dollie Thomas Lowe						2a. DATE OF DEATH 11 Month 14 Day Year 1968 2b. HOUR 12:20 P M					
3 SEX female		4. RACE white		5. DATE OF BIRTH August 1, 1894				6 AGE (In years lost 74 day) YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico			12b KIND OF BUSINESS OR INDUSTRY Shirt Factory		
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machine Operator			12b KIND OF BUSINESS OR INDUSTRY Shirt Factory		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Wicomico		13c CITY OR TOWN Hebron		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER ----		
14. FATHER'S NAME First Thomas Middle William Last Bennett						15. MOTHER'S MAIDEN NAME First Mary Middle Ellen Last Phillips					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No				16b SOCIAL SECURITY NO 218-03-0921		17 INFORMANT (Niece) R.D.2 Address Box 13A Mrs. Diane D. Hastings, Laurel, Delaware					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4129 (b) Arteriosclerotic cardiovascular disease, de- DUE TO, OR AS A CONSEQUENCE OF compensated. (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral thrombosis with left hemiplegia.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. V. Maldve, M. D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11/14/68			
22d. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.						22e. ADDRESS Deer's Head State Hospital, Salisbury, Md					
23a. BURIAL, CREMAT OR REMOVAL (Specify) Burial		23b. DATE Nov. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens, Salisbury, Wicomico, Maryland		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland					
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REG STRAR NOV 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR M	
George						Maddox		November 28 1968		8:15 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 24 HRS		8 UNDER 24 HRS	
Male		Negro		Sept. 15, 1897		71 YRS.		MONTHS DAYS HOURS MIN		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md - U.S.		U.S.				Wicomico					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital				SELF EMPLOYED					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md		SOMERSET		Upper Hill				Box 185 Upper Hill			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S M A DEN NAME		First Middle Last	
Unknown								Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		220-14-5883		ETHEL Maddox (WIFE)		Upper Hill					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Pneumonia -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		DUE TO, OR AS A CONSEQUENCE OF			
493X											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		Ca. Prostate		Uremia -							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11/26/1968, to 11/28/1968, that (I) (we) last saw the deceased alive on 11/28/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dia) (did not) view the body after death.		22b. SIGNATURE		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		12/1/68		WESTOVER		WESTOVER Md					
24 FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Anthony E. Ware, Crispfield Md.		DEC 3 1968		Charles Yundee							



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16657

16671

1 DECEASED-NAME (Type or print) LELA Collins MASON			2a DATE OF DEATH Month November Day 23 Year 1968			2b. HOUR 7:45 PM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH Nov. 4, 1895		6 AGE (In years last birthday) 73 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.	
10 CITY OR TOWN OF DEATH Salisbury-Peninsula		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) General Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY --	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE Maryland		13b. COUNTY Worcester		13c CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER R.F.D. 2		14 FATHER'S NAME First Middle Last William -- Collins		15. MOTHER'S MAIDEN NAME First Middle Last Minnie Jane Collins			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 218-05-8484		17 INFORMANT Address Maurice E. Mason, Pocomoke City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 4354 DUE TO, OR AS A CONSEQUENCE OF (b) 4354 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. 4354 DUE TO, OR AS A CONSEQUENCE OF (c) 4354 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm street, factory, office building etc)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from Nov. 15 , 19 68 , to Nov. 23 , 19 68 , that (I) (we) last saw the deceased alive on Nov. 23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE David J. Gilmore, M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (Type) David J. Gilmore, M.D.				22e ADDRESS Medical Center, Salisbury, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 11-26-1968		23c. NAME OF CEMETERY OR REMOVAL First Baptist		23d LOCATION (City or Town) (County) (State) Pocomoke City-Wor.-Md.	
24 FUNERAL DIRECTOR Robert H. Watson				ADDRESS Pocomoke City, Md.		25a REC'D BY REGISTRAR NOV 29 1968	
				25b REGISTRAR'S SIGNATURE Charles Judge			



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VR 1-1-68
30M REV 1/68

16658

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1967

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 8:25 P.M.	
SAMUEL		FRANKLIN		MEYERS	November 19 1968			
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Male	White		June 6, 1901		67 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.			
Maryland	USA							
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
		Peninsula General Hospital		Retired Grocer		Grocery		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
Maryland		Wicomico		Salisbury		R.D. 6, Baysinger Trailer		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last PK.
George				Meyers	Emma			Elliott
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO.		17 INFORMANT (Wife) R.D.6, Baysinger Trailer Park				
Yes		War I		Mrs. Beulah V. Meyers, Salisbury, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Poisoning</u> 509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 11-5, 1968, to 11-19, 1968, that (I) (we) lost saw the deceased alive on 11-19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <i>W.B. Smith</i>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED November 20, 1968		
22d PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Dr. William B. Smith		402 S. Division Street, Salisbury, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		Nov. 22, 1968		Wicomico Memorial Park		Salisbury, Wicomico, Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND				NOV 21 1968				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16659

CERTIFICATE OF DEATH

1667

1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR		
DELLA			Moore	Mitchell	NOVEMBER 29 1968			11 A M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.	
FEMALE		Colored		May 16, 1922		46 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Bishop Del.		U.S.A.				Wicomico		Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital						Domestic		
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)			13b CITY OR TOWN			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d STREET AND NUMBER		
Bishop Del.			Salisbury			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			P.O. Box 454		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Isaac Moore			Anna Mae Massie								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
			221-18-6667			Thorina Purnell			45th St. Salisbury, Del.		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)).											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) 1535 Chlamydia - purging spinal col.											6 m
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b TIME OF INJURY HOUR A M Month Day Year 19											
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)											
21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE											
22c DATE SIGNED											
22d PHYSICIAN'S NAME (Type)											
22e ADDRESS											
23a BURIAL, CREMATION, REMOVAL (Specify)											
23b DATE											
23c NAME OF CEMETERY OR CREMATORY											
23d LOCATION (City or Town) (County) (State)											
24. FUNERAL DIRECTOR											
25a REC'D BY REGISTRAR											
25b REGISTRAR'S SIGNATURE											

MEDICAL CERTIFICATION

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VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1666A

1657

1. DECEASED NAME (Type or print) ANDRA MOHAMERY			2a. DATE OF DEATH Month November Day 25 Year 1968			2b. HOUR 10:05	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH May 30, 1904		6. AGE (In years last birthday) 64 YRS.	
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Deer's Head State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR INDUSTRY Seafood	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland COUNTY Somerset		13b. CITY OR TOWN Crisfield		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 774 B St.	
14. FATHER'S NAME First Unknown Middle Last			15. MOTHER'S MARDEN NAME First Unknown Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Archie Clay Crisfield Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retroperitoneal sarcoma (fibro) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 158X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that no (this hospital) attended the deceased from 11/13 , 19 68 , to 11/25 , 19 68 , that (X) (we) last saw the deceased alive on 11/25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.							
22b. SIGNATURE L. V. Maldve, M.D.		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/26/68			
22d. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22e. ADDRESS Deer's Head State Hospital, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/30/68		23c. NAME OF CEMETERY OR CREMATORY Asbury		23d. LOCATION (City or Town) (County) (State) Crisfield 9/11/1	
24. FUNERAL DIRECTOR'S ADDRESS Anthony E. Ward Crisfield Md.		25a. REC'D BY REGISTRAR DATE DEC 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

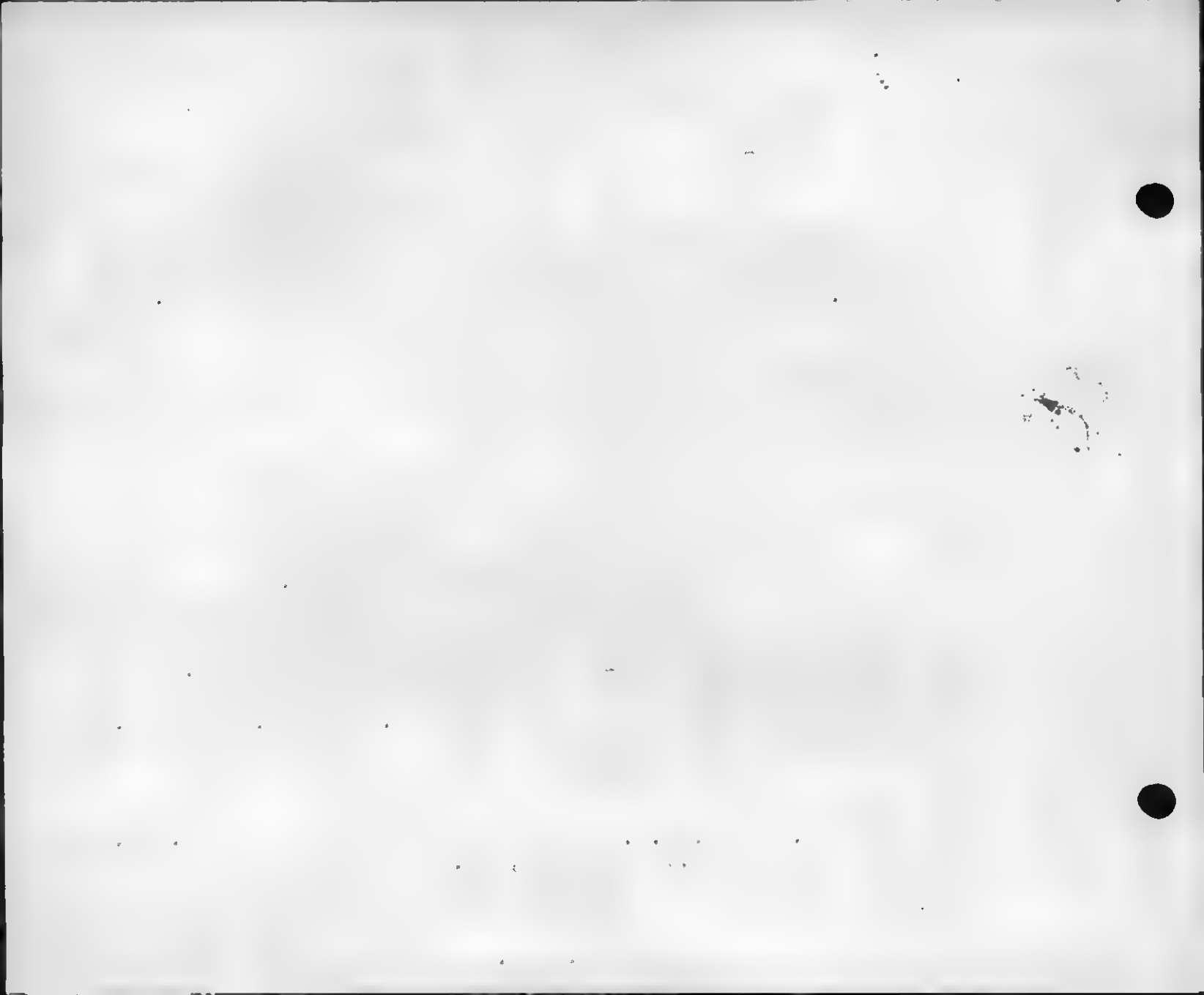
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16662

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1667.

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF EST DEATH MATED		Month	Day	Year	2b HOUR A M			
EVA		HANNAH		MOORE				11-13-68		11	13	1968	11:45 A			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		2c DATE PRONOUNCED DEAD Month		Day	Year	2d HOUR A M			
F	W	2-4-93		75 YRS					11		13	1968	11:45 A			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH										
Delmar		U.S.				Wicomico		Md								
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY										
Salisbury		Peninsula General		Housework		Home										
13a USUAL RESIDENCE (Where deceased admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER								
Md.		Wicomico		Delmar				400 East St.								
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last		
Riall		Herkings						Cora						Lelater		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO (If yes give year or dates of service)		17 INFORMANT		ADDRESS										
		212-20-5826		Lillian Schreyer		Richmond, Va.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho pneumonia													days			
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF																
DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
Secondary anemia due to multiple fractures.																
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?													20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)												
		11-11-68		Fell down stairs at home.												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State												
		own home		400 East St., Delmar, Wicomico, Md.												
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Notura. causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE		Earl L. Royer, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED Nov. 14, 1968				
EXAMINER'S NAME (Type)		409 Camden Ave., Salisbury, Md.														
ADDRESS (Street, city, town, or county)																
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)										
Burial		11/15/68		St. Stephen's		Delmar		Sussex Del								
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE										
Marvel Funeral Home, Delmar, Del.				NOV 18 1968		Charles Judge										



FOR STATE HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16662

DIVISION OF VITAL RECORDS-301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16670

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR		
GLADYS			VIRGINIA			MOORE			11/25			1968 6:50 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 IF UNDER 24 HRS HOURS	10 IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD			2d HOUR			
Female	White	August 8, 1900	68 YRS					November 25			1968 6:50 AM			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md		
Maryland			USA						WICOMICO					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USJA OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			Housewife			---					
13a USJA RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Wicomico			Parsonsbury			YES <input type="checkbox"/> NO <input type="checkbox"/>			R.D. 1, Wango		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT (Son) ADDRESS		
Purnell L.			Phillips			Jennie Mae			Hales			Mr. Oliver J. Moore, Pittsville, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4 7a DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)			11-18-68			Fractured neck of left femur			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			21a INJURY OCCURRED			21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
4341 Fractured neck of left femur.			WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			own home			Fell at own home.					
22a I certify that I took charge of the remains described above, held on death resulted from			22b DATE SIGNED			22c DATE SIGNED			22d DATE SIGNED					
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			November 26 / 1968			November 26 / 1968			November 26 / 1968					
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
			Burial			Nov. 27, 1968			Pittsville Cemetery			Pittsville, Wicomico, Maryland		
24 FUNERAL DIRECTOR			25a REC'D BY REG. STRAR			25b REG. STRAR'S SIGNATURE			25c REC'D BY REG. STRAR			25d REG. STRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND			DEC 2 1968			f Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
Margaret		Eaton		Newman		11		Month 16 Day 60 Year	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR	
Female		White		2/24/1873		95 YRS		1:15 AM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
MARYLAND		USA				Wicomico		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury		Deer's Head State Hospital		Postmistress - Retired					
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3a IN DE CITY - HTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Queen Ann's		Church Hill					
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
JOHN		EATON		MARY		E. ELLIOTT			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (approx. year)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address			
No		xx		MRS. MOLLIE COPPAGE - CHURCH HILL MD.					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism									10 hrs.
413 DUE TO OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Cardiovascular									Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO OR AS A CONSEQUENCE OF (c) Disease									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
443X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home farm street, factory, office building etc)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 28, 1968, to Nov. 16, 1968, that (I) (we) last saw the deceased alive on Nov. 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		L. V. Maldve, M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 11/16/68	
22d PHYSICIAN'S NAME (Type)		L. V. Maldve, M.D.		22e ADDRESS		Deer's Head Hospital, Salisbury, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		Nov. 19		CHURCH HILL		CHURCH HILL MD.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE			
Edgar L. Lane Church Hill Md.				NOV 20 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

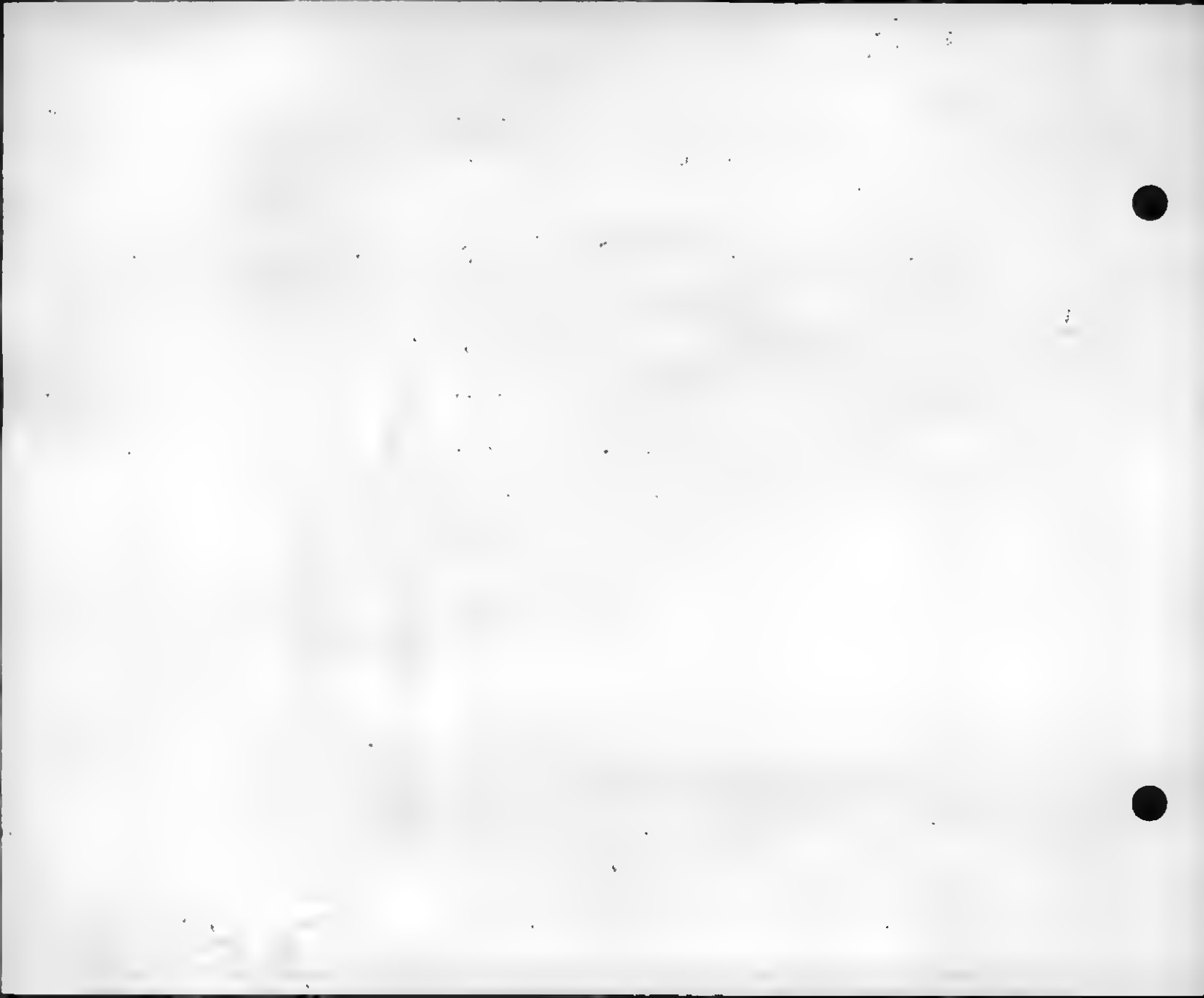
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16664

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10173

1. DECEASED NAME (Type or print) Ethel		First Middle Last Northam		2a. DATE OF DEATH Month 11 Day 23 Year 68		2b. HOUR 11:45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 9, 1894		6. AGE (In years last birthday) 73 YRS	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico Nursing Home, Booth St., Salisbury, Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Neg. Nurse		12b. KIND OF BUSINESS OR INDUSTRY Medicine	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last Henry C. Northam		15. MOTHER'S MAIDEN NAME First Middle Last Sallie Hancock			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 220-30-8991		17. INFORMANT Address Mr. S. Otis Northam, Snow Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 4227 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 10 yr							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept 20, 1968 , to 11/23, 1968 , that (I) (we) last saw the deceased alive on 11/22 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James Thompson				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/>		22c. DATE SIGNED 11/23/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/25/1968		23c. NAME OF CEMETERY OR CREMATORY Whatcoat Cemetery		23d. LOCATION (City or Town) (County) (State) Snow Hill, Maryland	
24. FUNERAL DIRECTOR Shirley C. Brown				ADDRESS Snow Hill, Md.		25a. REC'D BY REGISTRAR DATE NOV 27 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M 11-27-68

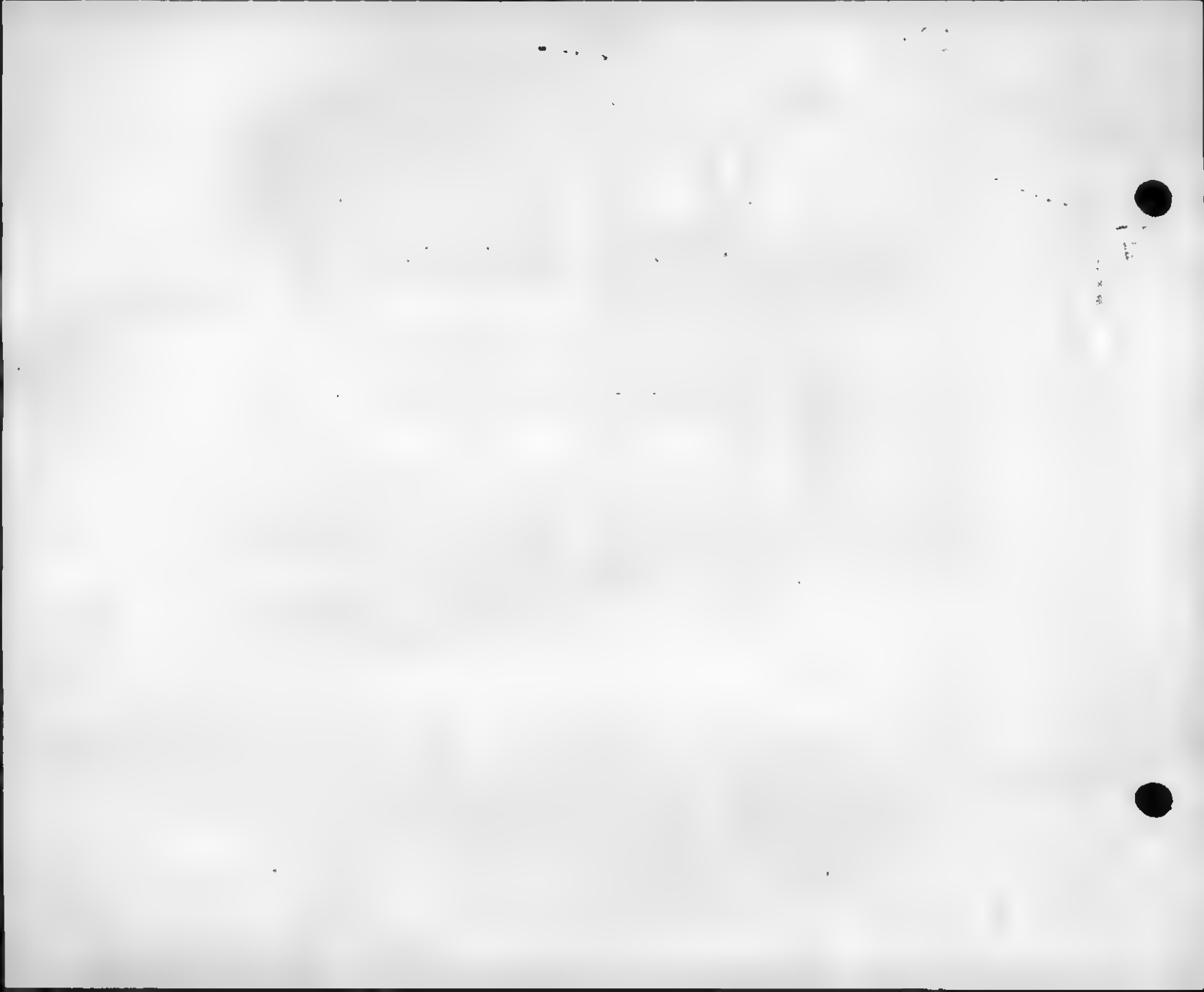
16665

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10-27-68

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOURS M	
ROBERT			HENRY	Norwood	November 27 1968		6:28 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	White		June 8, 1918		50 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		USA				Wicomico Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital		Painter		Painting		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY, LIM TST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Wicomico		Salisbury				505 E. College Ave.
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
William Norwood		Etta Hicks						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT (Wife) 505 Address E. College Ave.				
Yes War II		215-03-6934		Mrs. Rachel J. Norwood, Salisbury, Maryland				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumococcal Meningitis								5 days
2001 DUE TO, OR AS A CONSEQUENCE OF (b) R.L.L. pneumonia?								3 days
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
Chronic emphysema								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from 11-23-68, 19, to 11-27, 1968, that (1) (we) last saw the deceased alive on 11-27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (d) (did not) view the body after death.								
22b. SIGNATURE John T. Bulkeley MD				22c. DATE SIGNED 11-27-68				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
Dr. John T. Bulkeley				S. Salisbury Blvd., Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Nov. 30, 1968		Wicomico Memorial Park		Salisbury, Wicomico, Maryland		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND				DEC 2 1968		Charles Judge		



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Director, page 3 should be filed with

VR A15
30M REV.

16666

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16630

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First MILDRED		Middle BLANCHE		Last <i>Phillips</i>		2a. DATE OF DEATH Month <i>November</i>		Day <i>15</i>		Year <i>1968</i>		2b. HOUR <i>10:10</i> M													
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>December 27, 1899</i>		6. AGE (In years last birthday) <i>68</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.																	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md																					
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Shirt Factory</i>																					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIM. '57 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>402 Truitt Street</i>																			
14. FATHER'S NAME First <i>Grafton</i>				Middle <i>Mills</i>				Last <i>Lydia</i>				15. MOTHER'S MAIDEN NAME First <i>Lydia</i>				Middle <i>Hatton</i>				Last <i>Hatton</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b. SOCIAL SECURITY NO. <i>216-07-3951</i>				17. INFORMANT (Husband) <i>Mr. Paul B. Phillips, Salisbury, Maryland</i>				Address <i>402 Truitt St.</i>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY.																											
IMMEDIATE CAUSE (a) <i>Myocardial Failure</i>																											
DUE TO, OR AS A CONSEQUENCE OF																											
(b) <i>Acute Myocardial Infarction</i>																<i>28 hours</i>											
DUE TO, OR AS A CONSEQUENCE OF																											
(c) <i>ASC.V.A</i>																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																											
<i>tavi</i>																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town				County				State							
22a. I certify that (I) (this hospital) attended the deceased from <i>11-15</i> , 19 <i>68</i> , to <i>11-15</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE <i>Joseph C. Fitzgerald, M.D.</i>																DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>November 15, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dr. Joseph C. Fitzgerald</i>																22e. ADDRESS <i>Salisbury, Maryland</i>											
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>Nov. 18, 1968</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Hebron Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Hebron, Wicomico, Maryland</i>															
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</i>																25a. REC'D BY REGISTRAR <i>NOV 21 1968</i>				25b. REGISTRAR'S SIGNATURE <i>Richard S. Judah</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
304 REV. 1-68

16667

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16681

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Roger Sherman POWELL</i>			2a. DATE OF DEATH Month <i>NOVEMBER</i> Day <i>16</i> Year <i>1968</i>			2b. HOUR <i>3:12 PM</i>	
3. SEX <i>MALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov. 3 1896</i>		6. AGE (In years last birthday) <i>72</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.	
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Peninsula General Hospital</i>		12a. US. A. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Police Officer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>1727 1/2</i>		13b. CITY OR TOWN <i>Salisbury</i>		13c. INSIDE CITY LAW <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13d. STREET AND NUMBER	
14. FATHER'S NAME First <i>Theodore</i> Middle <i>Powell</i> Last <i>Powell</i>			15. MOTHER'S M. A. N. NAME First <i>Anna</i> Middle <i>Libbons</i> Last <i>Libbons</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>220-32-0068</i>		17. INFORMANT Name <i>Mrs. Bertha H. Powell</i> Address <i>Princeton</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <i>Myocardial Infarction</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i>Coronary Artery Disease</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<i>Chronic Pulmonary Emphysema</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/14/68</i> to <i>11/16/68</i> , that (I) (we) last saw the deceased alive on <i>11/16/68</i> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>[Signature]</i>						22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11/19/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Manokin Pre. Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Princeton Anne Arundel</i>	
24. FUNERAL DIRECTOR <i>Lewis R. Wilson</i>				25a. REC'D BY REGISTRAR <i>[Signature]</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16668

16668

1. DECEASED-NAME (Type or print) Olin Lee Pusey			2a. DATE OF DEATH Month November Day 6 Year 1968		2b. HOUR 12 P. MIN 00
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 29, 1901		6. AGE (In years last birthday) 67 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Wicomico		10. CITY OR TOWN OF DEATH Salisbury			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR IND. STRY Truck	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Worcester		13b. CITY OR TOWN Snow Hill		13c. STREET AND NUMBER 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Eugene Middle Pusey Last Hamblin			15. MOTHER'S MAIDEN NAME First Rosa Middle Hamblin Last Hamblin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 216561620		17. INFORMANT Address Mrs. Georgia E. Pusey, Snow Hill Md	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 4:22 P. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Runddle cerebral a thrombosis (c) Generalized cerebral arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 24 hrs. Yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332 X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. 11/5/68 Month 11 Day 5 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No 11/5/68 City or Town 11/6/68 County 11/6/68 State 11/6/68	
22a. I certify that (I) (this hospital) attended the deceased from 11/5/68 to 11/6/68 , that (I) (we) last saw the deceased alive on 11/6/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) [Signature]				22e. ADDRESS [Signature]	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/9/68		23c. NAME OF CEMETERY OR CREMATORY Bates Meth.	
23d. LOCATION (City or Town) (County) (State) Snow Hill Maryland		24. FUNERAL DIRECTOR [Signature]			
25a. REC'D BY REGISTRAR NOV 12 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



22



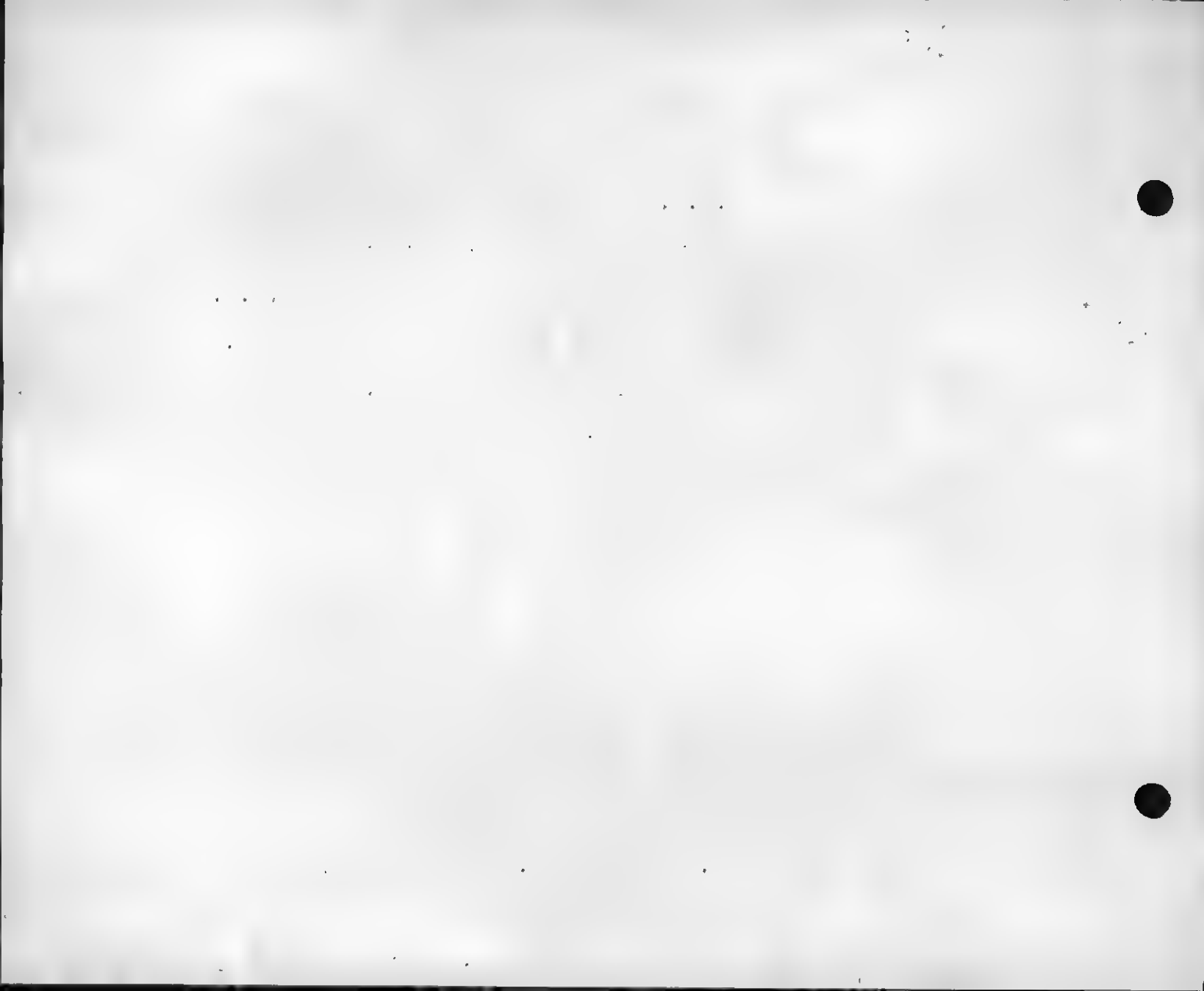
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) RUSSELL HERMAN			First Middle Last			2a. DATE OF DEATH NOVEMBER 26 1968			2b. HOUR 3 45 AM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH June 26, 1893			6. AGE (In years last birthday) 75 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Wicomico Md		
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Worcester			13c. CITY OR TOWN Pocomoke			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER R.F.D. 3			14. FATHER'S NAME First Middle Last John Purnell Redden			15. MOTHER'S MAIDEN NAME First Middle Last Cordelia F. Mason					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) --			16b. SOCIAL SECURITY NO unk			17. INFORMANT Mrs James T. Abell, Pocomoke City, Md.			Address		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of prostate & metastases											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 177X Hepatitis, unknown etiology											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard E. Hughes						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 11/26/68		
22d. PHYSICIAN'S NAME (Type) Richard E. Hughes, M.D.						22e. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial			23b. DATE 11-28-1968			23c. NAME OF CEMETERY Goodwill Methodist			23d. LOCATION (City or Town) (County) (State) Pocomoke City - Wor. - Md.		
24. FUNERAL DIRECTOR Robert H. Watson						ADDRESS Pocomoke City, Md.			25a. REC'D BY REGISTRAR Charles Judge		
25b. REGISTRAR'S SIGNATURE Charles Judge						DATE NOV 29 1968					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

<div>16670</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>1034</div>										
1 DECEASED-NAME (Type or Print)		First JUDY		Middle ANN		Last REID		2a. DATE KNOWN OF EST DEATH MATED <input checked="" type="checkbox"/> 11-3-68 19		2b. HOUR 2 A.M.
3 SEX Female	4 RACE AA	5. DATE OF BIRTH 12-26-67		6. AGE (In years last birthday) YRS 10 MONTHS 8 DAYS		IF UNDER 1 YEAR HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 11 Day 3 Year 1968		2d. HOUR 3:30 A.M.
7a. BIRTHPLACE (State or foreign country) Wic. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route 4, Dykes Road		
14. FATHER'S NAME First Isiah		Middle Reid		Last Delphia		15. MOTHER'S MAIDEN NAME First Hampton		Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (If yes give year or dates of service)		17. INFORMANT ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis</u> <u>484X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Earl L. Royen M.D. 409 Camden Ave., Salisbury, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Nov. 4, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-5-68		23c. NAME OF CEMETERY OR CREMATORY Tyaskin Cem.		23d. LOCATION (City or Town) Tyaskin, Wicomico, Md.		(County) (State)		
24. FUNERAL DIRECTOR Messick Funeral Home, Bivalve, Md.		25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 Film GL 07
12/3/68 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
16671 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1055.0

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR							
JOHN JOSEPH FRANCIS SACCA						11-19-68			19			M							
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR					
Male		White		7-7-18		50 YRS		MONTHS DAYS		HOURS MIN		Month 11 Day 19 Year 1968		M					
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH							
Philadelphia, Pa.				USA								Wicomico Md							
1d CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b KIND OF BUSINESS OR INDUSTRY							
Salisbury				Peninsula General				Foreman				Constructive							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?				13e STREET AND NUMBER			
Md.				Worcester				Ocean City				No				804 S. Baltimore Ave.			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME															
Frank J. Sacca				Lena Juliana															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17. INFORMANT				ADDRESS							
Yes				W.W. II				215-14-3778				Ms. Nancy Sacca (wife)							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Electrocution</u> <u>1201</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
												sudden							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>9175</u>																			
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								2d AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)											
				11:45 AM 11-19-68				Was holding onto crane when boom struck high tension wire											
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State											
				road construction site nr. Md. State College, Somerset,				Md.											
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion on death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED							
Earl L. Royer, M.D.				409 Camden Ave., Salisbury, Md								Nov. 23, 1968							
23a BURIAL CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)							
Burial				11-23-68				Evergreen Cemetery				Berlin, Worcester, Md.							
24 FUNERAL DIRECTOR ADDRESS								25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Burbage Funeral Home, Berlin, Md.								DATE NOV 27 1968				Charles Judge							

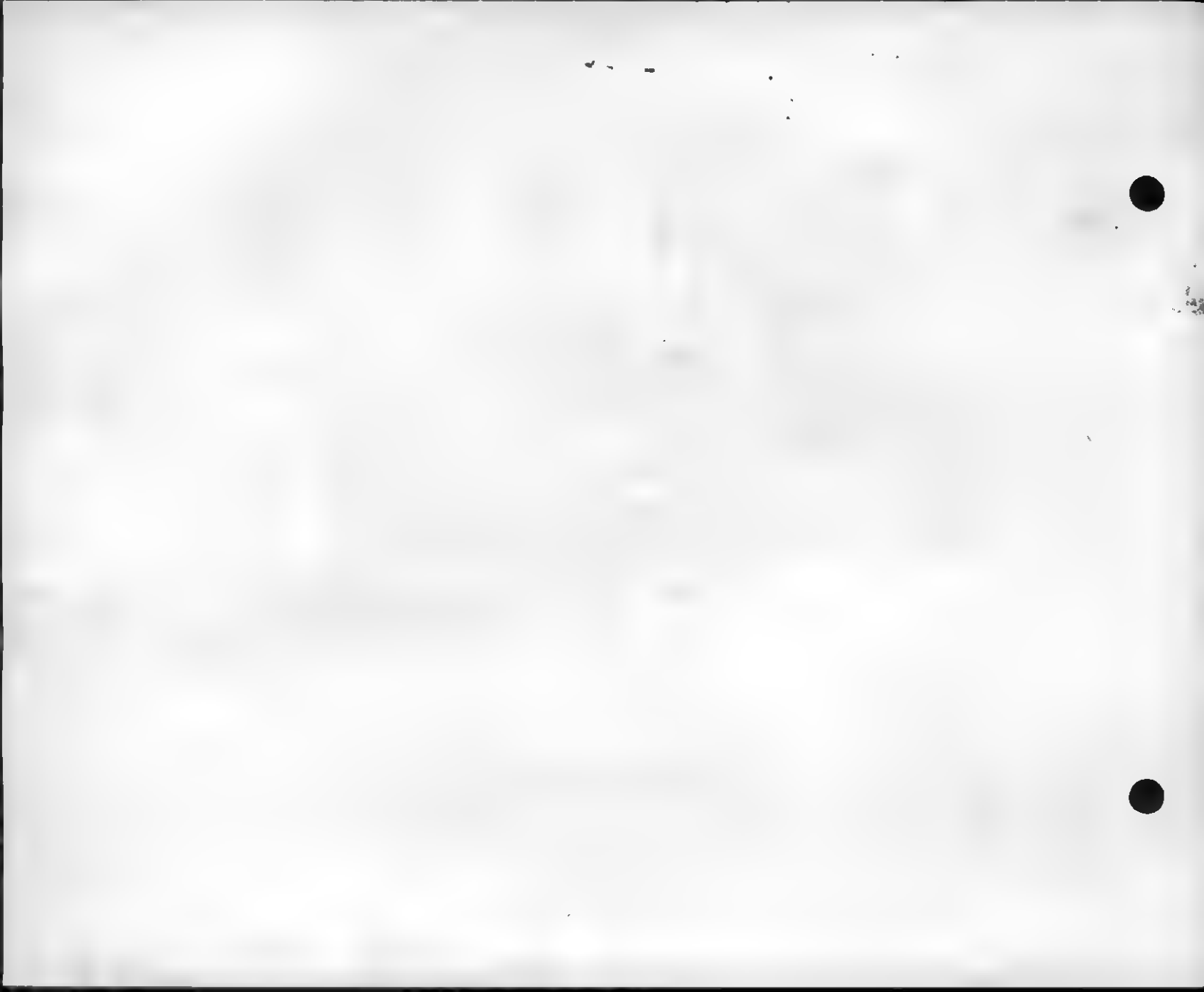


CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>68</u>		2b. HOUR <u>9:20</u> P. M.	
MAE		BELL			SUGGS			
3. SEX <u>FEMALE</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>May 4, 1891</u>			6. AGE (In years last birthday) <u>77</u> YRS.	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS HOURS <u> </u> MIN. <u> </u>
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Wicomico</u> Md.				
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Peninsula General Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Seamstress</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Shirt Factory</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Wicomico</u>		13c. CITY OR TOWN <u>Eden</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>R.D. 1, Camden Ave. Extd.</u>		
14. FATHER'S NAME First <u>Henry</u> Middle <u>Taylor</u> Last <u>Gray</u>		15. MOTHER'S MAIDEN NAME First <u>Sarah</u> Middle <u>Gray</u> Last <u>Gray</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>215-12-6833</u>		17. INFORMANT (Daughter) <u>R.D. 1</u> Address <u>Camden Ave. Extd. Mrs. Mae B. Donalds, Eden, Maryland</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>2971</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Thromboembolism → Atherosclerosis</u> years.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>296X</u> <u>ASSVD</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natally medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-1-68</u> 19 <u> </u> , to <u>11-4-68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>11-4-68</u> 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Joseph C. Fitzgerald, M.D.</u> DEGREE <u> </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>November 4, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>Dr. Joseph C. Fitzgerald</u>					22e. ADDRESS <u>Medical Center, Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 7, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCAT ON (City or Town) (County) (State) <u>Salisbury, Wicomico, Maryland</u>			
24. FUNERAL DIRECTOR ADDRESS <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR DATE <u>NOV 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16673

CERTIFICATE OF DEATH

16687

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR a	
Jay		-	Swift		November 9, 1968		10:45	
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS
male	white		Feb. 28, 1896		72 YRS.	MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland	U.S.A.				Wicomico		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Pine Bluff State Hosp.		Laborer				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland		Somerset		Marion				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Fred		-	Swift		Jennie		-	Ennis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		220-01-8396		records of		Pine Bluff State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u>								8 days
4269 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
351X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from Aug. 7, 1968, to Nov. 9, 1968, that (I) (we) last saw the deceased alive on Nov. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>E. P. Ritchings</i>						22c. DATE SIGNED Nov. 10, 1968		
22d. PHYSICIAN'S NAME (Type)		E. P. Ritchings, M.D.		22e. ADDRESS Pine Bluff State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Nov. 12, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		23d. LOCATION (City or Town) (County) (State) Kingston, Md. Somerset		
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md. 21817				25a. REC'D BY REGISTRAR DATE NOV 13 1968		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Bp

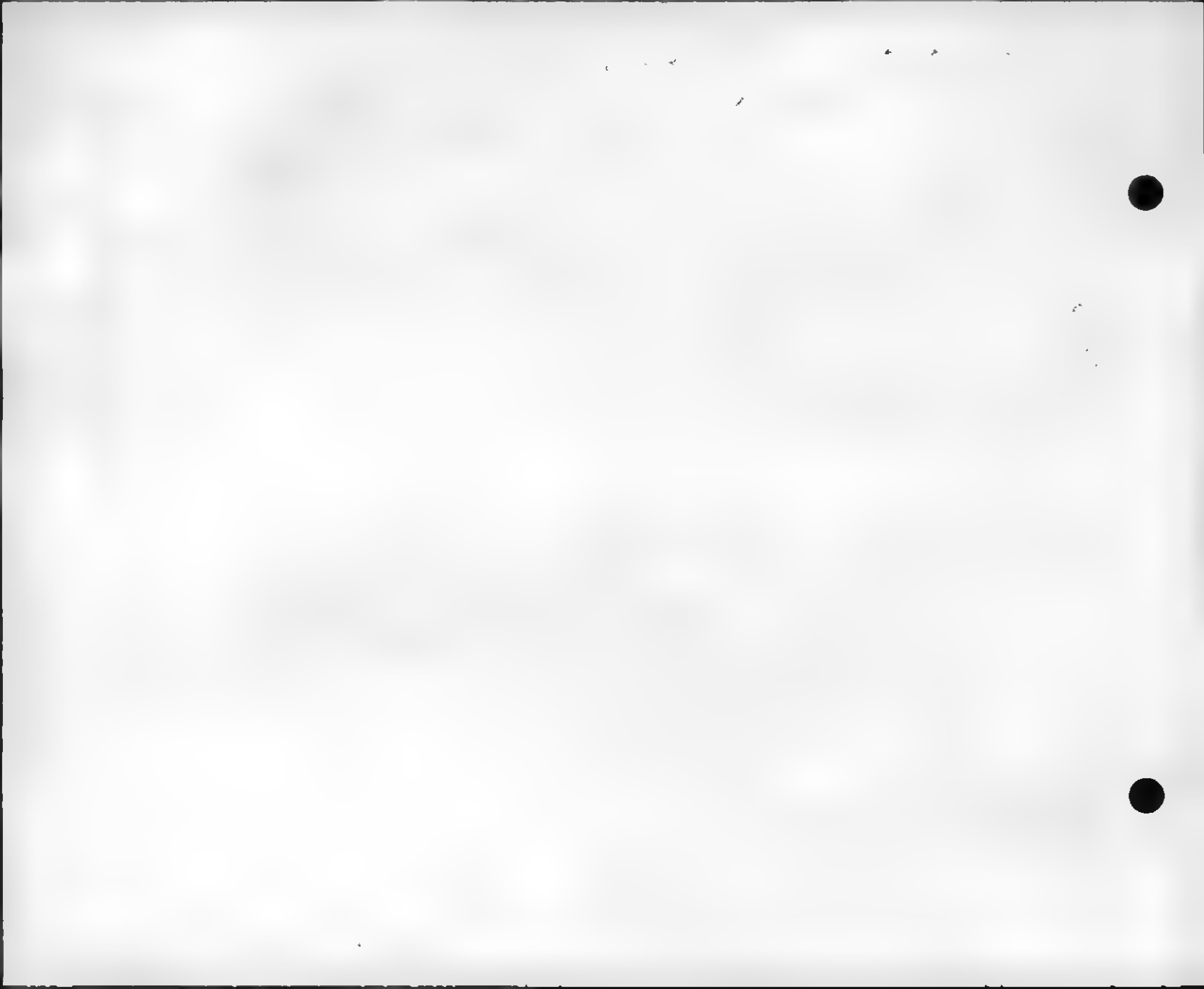
VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16674

16688

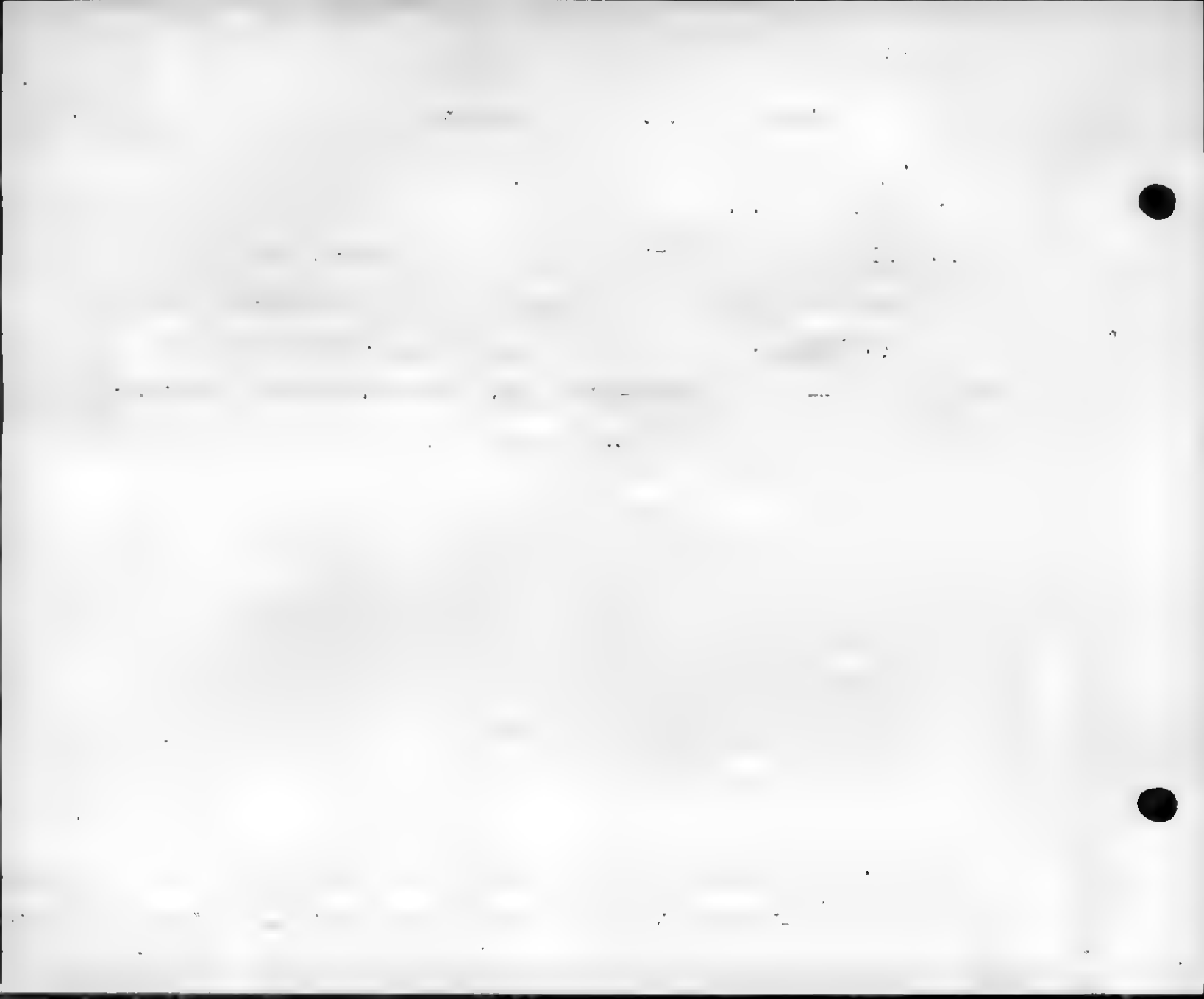
1. DECEASED NAME (Type or print) HATTIE MARIAN TIMMONS		2a. DATE OF DEATH Month November Day 7 Year 1968		2b. HOUR 8:25 AM
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH May 1, 1899		6. AGE (In years last birthday) 69 YRS.
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Wicomico Md.	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House Wife	12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MARYLAND	13b. COUNTY Wicomico	13c. CITY OR TOWN Hebron	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 207 Main Street
14. FATHER'S NAME First Middle Last Joseph Frank Milligan		15. MOTHER'S MAIDEN NAME First Middle Last Sallie Ann Taylor		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Grandson) Address Mr. L. Tim White, Hebron, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Chronic cholelithiasis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 2 wks 4-5
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 11-5 , 19 68 , to 11-7 , 19 68 that (I) (we) last saw the deceased alive on 11-7 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Frank E. Kent		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 11-7-68	
22d. PHYSICIAN'S NAME (Type) FRANK E. KENT		22e. ADDRESS MEDICAL CENTER, SALISBURY, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 9, 1968	23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens	23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR NOV 12 1968	25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
16675 CERTIFICATE OF DEATH 16679													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Walter Albert VanAuken						Month 11 Day 9 Year 1968			2:45 M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS		
Male		White		12-10-1903			64 YRS		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Connecticut			U.S.A.						Wicomico			Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Pittsville			Sixty-Foot Road			Retired Welder			Welding				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Wicomico			Pittsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Sixty-Foot Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
UNKNOWN			UNKNOWN										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
No			048-05-1478			Mrs. Frances E. VanAuken, See Sec. 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Ca.</u>													
1621 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
1621													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>9/3/1968</u> , to <u>11/9/1968</u> , that (I) (we) last saw the deceased alive on <u>10/5/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED										
<u>DR. O. J. BURTON</u>			<u>11-11-1968</u>										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
DR. O. J. BURTON			SALISBURY, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			11-12-1968			Fairfield Memorial Park			Stamford, Fairfield, Connecticut				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Hill Funeral Home			Salisbury, Maryland			DATE NOV 12 1968			J. Charles Judge				
William T. Balsem													



16678

16590

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR 11 45 AM	
Mable Esther Venables					November 17 1968			
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (n years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female	White	Aug 3, 1893			75 YRS			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	U.S.			Wicomico Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		General Hospital			Retired Public Health		Nurse	
13a. USUAL RESIDENCE (Where deceased lived, if institution, admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER			
Maryland		Salisbury		YES	24 East State ST.			
14. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
Curtis				Emmet	Lellie			Annein
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT				
		217-36-1922		Mrs. John Heorn Salisbury Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, metastatic from breast</u> <u>11/4X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8/6/68</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>170x</u>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b SIGNATURE <u>Richard E. Hughes</u>		DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS. <input checked="" type="checkbox"/>
								22c DATE SIGNED <u>11/17/68</u>
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		11/19/68		St. Stephens		Salisbury Sussex Co. Md.		
24 FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR DATE						
William M. Morris		NOV 20 1968						
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

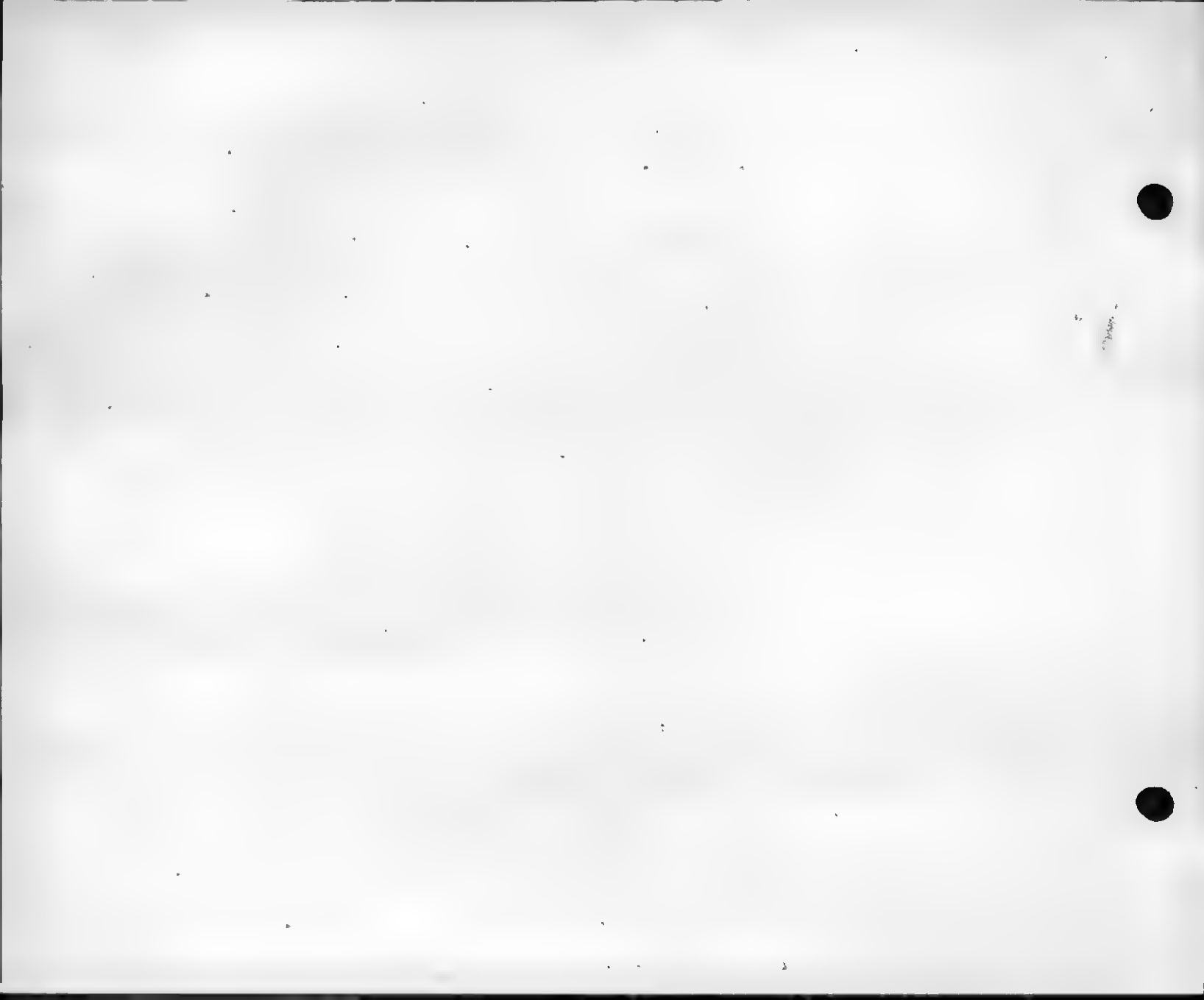
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																					
CERTIFICATE OF DEATH																					
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR												
EDWARD			WEST			Month 11 Day 12 Year 1968			11 P M												
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS.										
Male		White		Jan 6, 1886			82 YRS.		MONTHS DAYS		HOURS MIN										
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH												
Md			U.S.						Wicomico			Md									
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY									
Delmar				RD 3				Farmer				Form									
13a USUAL RESIDENCE (Where deceased lived if institution admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY & M 15?		13e STREET AND NUMBER											
Md				Wicomico		Delmar		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD 3											
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME																	
First Middle Last Jacob West				First Middle Last Mary Hekkins																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO		17 INFORMANT				Address											
				220-52-8038		Mr & Mrs Bessie E. West				Delmar Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) myocarditis (chronic)												5-7 days.									
+ 120 DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension																					
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
14-2 X Immobilized arteries																					
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION		City or Town		County		State							
								Street or R.F.D. No.													
22a. I certify that (I) (this hospital) attended the deceased from 1968, 19, to 11-12-68/19, that (I) (we) last saw the deceased alive on 11-10-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE												DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED	
Frank Lewis														<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		11-20-1968.	
22d PHYSICIAN'S NAME (Type)												22e. ADDRESS									
Frank Lewis												Wicomico Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)							
Burial				11/14/68		Morton Corn				Delmar		Sussex		Del.							
24 FUNERAL DIRECTOR												ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William S. Morrell												Delmar, Del.		DATE NOV 25 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and in only event, within 72 hours after death, should be filed with the State Dept of Health prior to burial, cremation, or removal.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Renerva ELEANOR West</i>			First Middle Last			2a. DATE OF DEATH 11 Month 17 Day 68 Year			2b. HOUR 12:35 P.M.	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>MARCH 19 1907</i>			6. AGE (In years last birthday) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>DELAWARE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.				
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DELAWARE</i>			13b. COUNTY <i>SUSSEX</i>		13c. CITY OR TOWN <i>SEAFORD</i>		13d. INS. DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>152 HOLLYOAK DRIVE</i>	
14. FATHER'S NAME <i>WILLIAM HITCHENS</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>SALLIE REBEL HITCHENS</i>			First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i>			16b. SOCIAL SECURITY NO <i>202-18-7161</i>		17. INFORMANT <i>NORMAN M. WEST</i>				Address <i>SEAFORD, DELAWARE</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND OFATH <i>14 days</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>120</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>11-3</i> , 19 <i>68</i> , to <i>11-17</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-17</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Joseph C. Fitzgerald</i> MD. DEGREE								22c. DATE SIGNED <i>NOV 17, 1968</i>		
22d. PHYSICIAN'S NAME (Type) <i>Joseph C. Fitzgerald</i>								22e. ADDRESS <i>SALISBURY, MARYLAND</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>NOV. 19, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ODD Fellows Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>SEAFORD SUSSEX DEL.</i>				
24. FUNERAL DIRECTOR <i>Rayner M. Watson</i>				ADDRESS <i>SEAFORD, DELAWARE</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
DATE <i>NOV 19 1968</i>										

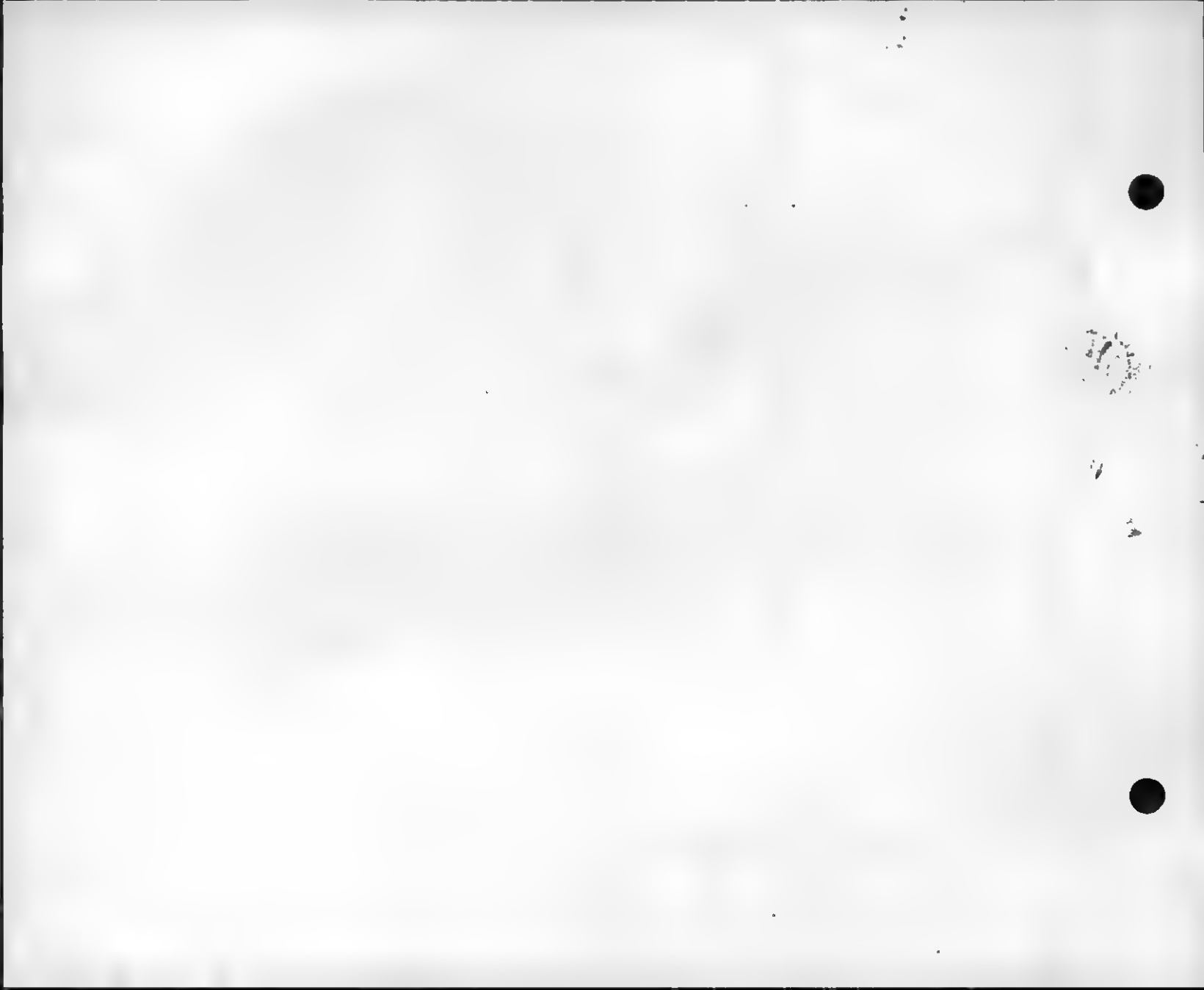
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Also known as Laura Middle Avalon Lost Wheatley) (Type or print) <u>AVA Wainwright WHEATLEY</u>					2a. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1968</u>			2b. HOUR <u>12</u> M			
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH June 24, 1897			6. AGE (In years lost birthday) <u>71</u> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Wicomico</u> Md.					
10. CITY OR TOWN OF DEATH <u>Salisbury</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Peninsula General Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>housework</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>				13b. COUNTY <u>Wicomico</u>		13c. CITY OR TOWN <u>Sharptown</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <u>W. George Wainwright</u> Middle <u>George</u> Last <u>Wainwright</u>					15. MOTHER'S MAIDEN NAME First <u>Jennie D.</u> Middle <u>Brinsfield</u> Last <u>Brinsfield</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>221-05-6763</u>		17. INFORMANT Address <u>Mrs. Laura E. Vaughn, Pennsville, N. J.</u>						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4331</u> (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Carcinoma of Breast & metastasis</u> <u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. F YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-7-68</u> , 19 <u>68</u> , to <u>11-10-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-10-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>11-14-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury, Md</u>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <u>Nov. 13, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Firemen's Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Sharptown, Maryland</u>			
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalburg, Maryland</u> ADDRESS						25a. REC'D BY REG STRAR DATE <u>NOV 14 1968</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16680

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI DEATH MATED			Month Day Year			2b HOJR					
CHARLES JARVIS WICKS, JR.						11/13			1968			M					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD					
Male		White		May 12, 1912		56 YRS						November 13 ^{day} 1968					
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH					
Virginia				USA								WICOMICO Md.					
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury				Peninsula General Hospital				Laborer				---					
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				3d INSIDE CITY - M I S?		13e STREET AND NUMBER			
Maryland				Wicomico				Salisbury				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		302 Pond Street			
14. FATHER'S NAME						15 MOTHER'S MAIDEN NAME											
Charles J. Wicks, Sr.						Kathryn Beatrice Powell											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO						17. INFORMANT (Friend) ADDRESS					
Yes War II												Mrs. G. Beverly Holland, Princess Anne, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>420</u>																	
19a. DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)						21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Injury <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b DATE SIGNED					
EXAMINER'S NAME (Type) Earl L. Royer, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						November 16 / 1968					
23a BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY					
Burial						Nov. 16, 1968						Olivett Cemetery					
24. FUNERAL DIRECTOR						ADDRESS						25a REC'D BY REGISTRAR					
HOLLOWAY & COMPANY, SALISBURY, MARYLAND												NOV 19 1968					
												25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
												23d LOCATION (City or Town) (County) (State) Worcester Co., Maryland					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16681

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
WILLIAM		EDWARD	WILLEY	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year
Male	White	March 17, 1904	64 YRS	MONTHS	DAYS	November 29		Month	Day	Year
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10b KIND OF BUSINESS OR INDUSTRY		
Maryland		USA				WICOMICO		House painting		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY				
Salisbury		Peninsula General Hospital		Retired Painter						
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		34 INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland		Wicomico		Eden		YES <input type="checkbox"/> NO <input type="checkbox"/>		R.D. 1		
14. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
Edward		Joseph	Willey		Elizabeth		Jane	Martin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT (Sister)		1730 ADDRESS		Riverside Drive		
No		215-16-8453		Mrs. Rayner Powell		Salisbury, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion										sudden
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH		P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER				22b DATE SIGNED				
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER				December 2 / 1968				
Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				
409 Camden Ave., Salisbury, Md.										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Dec. 2, 1968		Allen Cemetery		Allen, Wicomico, Maryland				
24 FUNERAL DIRECTOR		ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						DEC 3 1968		J. Charles Judge		

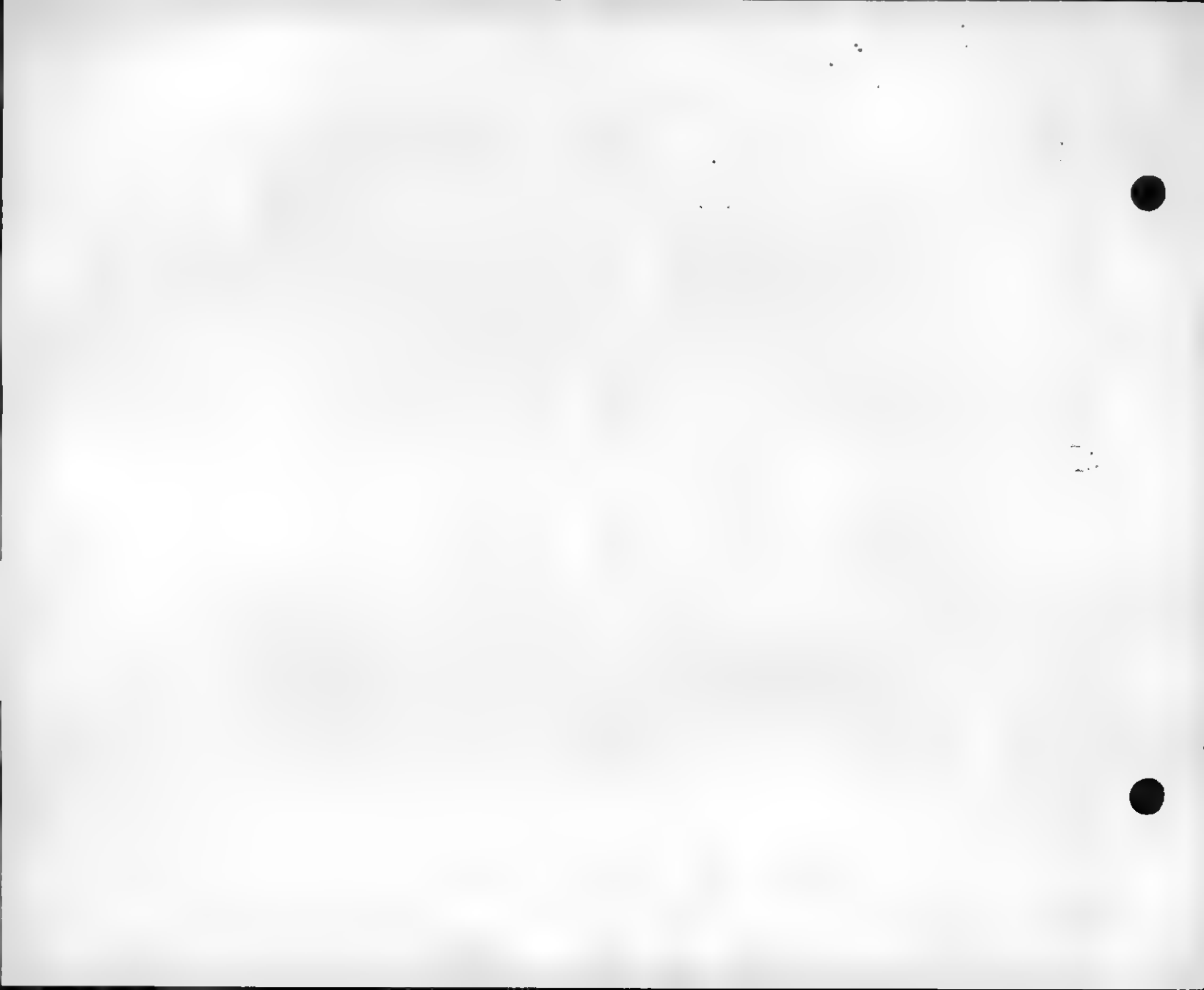


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

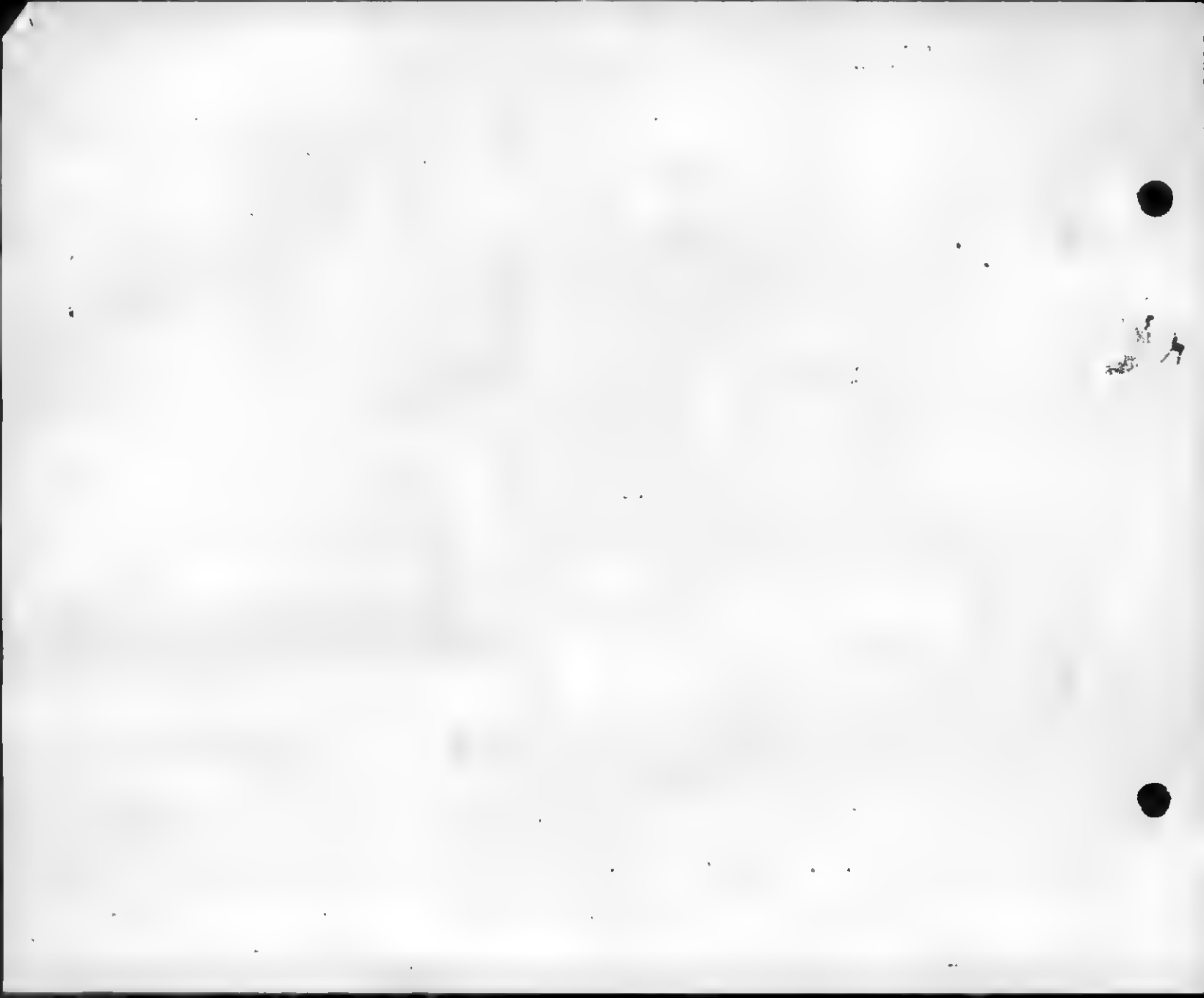
MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
16688													
Item #5, Film G407 12/9/68 km													
CERTIFICATE OF DEATH													
16696													
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR 3:35 AM				
Master			Ann			Williams			November 19 68				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
Female		Col.		10/15/1876			92						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Maryland			U.S.A.						Wicomico				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury				Peninsula General Hospital				Domestic					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland						Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		110 Evans Place			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
Benjamin			Goslee			Harriet			Weshiell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17. INFORMANT Address							
No						William Weshiell East Road Salisbury, Md.							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u>													
4330 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Nephrosclerosis and Cerebral Thrombosis</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 16, 1968</u> to <u>Nov 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov. 18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Thomas C. Heff</u> M.D.			22c. DATE SIGNED 11-21-68			22d. ADDRESS PINE BLUFF Rd., SALISBURY, Md.							
22e. PHYSICIAN'S NAME (Type)			22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 11/22/68			23c. NAME OF CEMETERY OR CREMATORY Green Acres			23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.				
24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u>			ADDRESS Salisbury, Md.			25a. RECEIVED BY REGISTRAR DATE NOV 26 1968			25b. REGISTRAR'S SIGNATURE <u>James J. J...</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>16688</div> <div>CERTIFICATE OF DEATH</div>									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
RALPH S. WILSON						November 21, 1968			10:00AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Colored		10-22-1900		68 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md
and		U.S.A.				WICOMICO			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Salisbury			Deer's Head State Hospital			Laborer			None
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Wicomico		Salisbury				300 Delaware Avenue
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Link			Link						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or UNKNOWN (If yes give war, or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address
No			29-077734			Media White			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									48 hrs
4120 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) <u>Hypertensive arteriosclerotic cardiovascular disease</u>									Years
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
443X Multiple strokelets									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			19 P.M.						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State				
22a I certify that (X) (this hospital) attended the deceased from September 16, 1968, to November 21, 1968, that (X) (we) last saw the deceased alive on November 21, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b SIGNATURE						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED	
C. H. Winnacott, M. D.								11/21/68 Maryland	
22d PHYSICIAN'S NAME (Type)						22e ADDRESS			
C. H. Winnacott, M. D.						Deer's Head State Hospital, Salisbury,			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		11-24-68		Green Acres		Salisbury Wicomico Md			
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Broder M West						DATE NOV 25 1968		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16684

CERTIFICATE OF DEATH

16698

1. DECEASED-NAME (Type or print) ROBERT FRANCIS (Frank) Wimbrow			2a. DATE OF DEATH Month November Day 11 Year 1968			2b. HOUR 9:50 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH February 9, 1896		6. AGE (In years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Samuel Hicks Wimbrow		15. MOTHER'S MAIDEN NAME First Middle Last Martha Eleanor (Mattie) Ellis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) Yes War I		16b. SOCIAL SECURITY NO. 217-36-0934		17. INFORMANT (Name and Address) Mrs. Beulah M. Wimbrow, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2. Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-10 , 19 68 , to 11-11 , 19 68 , that (I) (we) last saw the deceased alive on 11-11-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James L. Clifford M.D.				22c. DATE SIGNED 11-12-68		22d. PHYSICIAN'S NAME (Type) Dr. James L. Clifford	
22e. ADDRESS Medical Center Salisbury Md				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 14, 1968		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR NOV 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
- CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
GERTRUDE			CONSTANCE		YOUNG		NOVEMBER 18		1968 6 P. M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		White		May 12, 1894			74 YRS.		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. HOUR	
New York			USA				Wicomico			Md.	
11. CITY OR TOWN OF DEATH			12. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			13. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			14. KIND OF BUSINESS OR INDUSTRY		
Salisbury			General Hospital			House work					
15a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			15b. COUNTY		16. CITY OR TOWN		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		18. STREET AND NUMBER		
Maryland			Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		411 Somerset Avenue		
19. FATHER'S NAME			First		Middle		Last		20. MOTHER'S MAIDEN NAME		
(Unknown)							Nevins		(unknown) Riley		
21. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			22. SOCIAL SECURITY NO.		23. INFORMANT (Son)			Address			
No			215-56-9376		Mr. Charles C. Simpson, Salisbury, Maryland			411 Somerset Ave			
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u>										9 da	
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) DUE TO, OR AS A CONSEQUENCE OF	
										(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4200											
25a. DATE OF OPERATION			25b. CONDITION FOR WHICH OPERATION WAS PERFORMED			26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			26b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			27b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			27c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
28a. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work			28b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			28c. LOCATION Street or R.F.D. No. City or Town County State					
29a. I certify that (I) (this hospital) attended the deceased from <u>11-9</u> , 19 <u>68</u> , to <u>11-18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-18</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
29b. SIGNATURE											
<u>Wilber R. Ellis, Jr.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
29c. DATE SIGNED <u>11-18-68</u>											
29d. PHYSICIAN'S NAME (Type)			29e. ADDRESS								
Dr. Wilber R. Ellis, Jr.			Salisbury, Maryland								
30a. BURIAL, CREMATION, REMOVAL (Specify)			30b. DATE			30c. NAME OF CEMETERY OR CREMATORY			30d. LOCATION (City or Town) (County) (State)		
Cremation			Nov. 19, 1968			J. Wm. Lee & Sons Co.			Washington, D. C.		
31. FUNERAL DIRECTOR ADDRESS						32. REC'D BY REGISTRAR			32b. REGISTRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						DATE NOV 21 1968			<u>Charles Judge</u>		

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